DOCUMENT RESUME

ED 158 198 CG 012 793

AUTHOR Tesiny, Diane J.; And Others
TITLE Basic Adult Services: A Model Curriculum.
INSTITUTION State Univ. of New York, Albany. School of Social Welfare.
SPONS AGENCY New York State Dept. of Social Services, Albany.
PUB DATE 78
NOTE 453p.

EDRS PRICE MF-$0.83 HC-$24.77 Plus Postage.
DESCRIPTORS Adult Education; Adult Educators; *Age; Caseworkers; *Counselor Training; Curriculum Guides; *Educational Gerontology; Instructional Materials; *Older Adults; *Professional Continuing Education; Professional Training; *Staff Improvement

ABSTRACT

This curriculum guide and training manual has been developed for social services personnel working with older adults. This curriculum provides content material in the basic concepts of gerontology and service delivery and attempts to generate self-awareness of attitudes toward the aged and the aging process. The manual contains training modules in the areas of social gerontology, the aging process, interviewing and communicating with older clients, caseload management, legislation affecting the older adult, protective services, institutionalization, and grief. Each module consists of training goals, objectives, sample lectures, outlines, annotated bibliographies, and instructional strategies and resources. (Author/PFP)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED158198

BASIC ADULT SERVICES: A MODEL CURRICULUM

U S DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

C Meagher

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM

**SCHOOL OF SOCIAL WELFARE
CONTINUING EDUCATION PROJECT
THE UNIVERSITY AT ALBANY**

CG 012793

BASIC ADULT SERVICES:
A MODEL CURRICULUM

DIANE J. TESINY
EVELYN S. NEWMAN
RALPH G. BROCKETT

1978

ADULT SERVICES
CONTINUING EDUCATION PROJECT
SCHOOL OF SOCIAL WELFARE
STATE UNIVERSITY OF NEW YORK AT ALBANY

This document was produced under a contractual agreement between the New York State Department of Social Services and the Continuing Education Project of the School of Social Welfare, University at Albany, through the Research Foundation of State University of New York.

Continuing Education Project

Thomas J. Kinney, Director

Adult Services Training

Susan R. Sherman, Co-Director

Richard Beer
Ralph Brockett
Brian Caldwell
Robert Chesky

Kary Jablonka
Christine Meagher
Karen Nash
Diane Tesiny

Diane Girard
Eileen Pierce
Cecilia Pracher

ACKNOWLEDGEMENTS

We would like to thank previous staff members for their assistance in writing this curriculum. Laurel Winegar drafted the module on Problems of Aging, and Robert Famighetti compiled some of the bibliographies and film reviews.

We also appreciate the support present staff have given to the curriculum. Kary Jablonka wrote the module on Caseload Management and did the final editing of the videotape made to accompany the module on Protective Services for Adults. Brian Caldwell and Robert Chesky contributed objectives, discussion questions, and instructional strategies to many of the modules. They also devised, with Laurel Winegar, the case simulation found in the Protective Services for Adults module.

Special thanks also go to Fran Nosek for the many drafts she typed; to Glendora Jacobson for much of the final typing; to Sally Berdan and Jennifer Politis who provided assistance in the editing and production of the curriculum; and to Elace Comrie who designed the cover.

We also wish to acknowledge the assistance of the following staff of the New York State Department of Social Services: Richard Johnson, Robert O'Connell, Phyllis Baritz, Christine Singer and Mildred Ferris, who provided the outline of the program content, recommended articles and case material, and reviewed the curriculum in draft.

To conclude, the curriculum was a cooperative effort of the entire Adult Services project staff and our sincere thanks go to them all.

D. Tesiny
E. Newman
R. Brockett
April 1978

TABLE OF CONTENTS

Page

Introduction and General Training Instructions............ 1

Problems of Aging.................................... 19

Processes of Aging................................... 61

Ecology of Aging..................................... 101

Working with the Aged Client......................... 131

Interviewing and Communication Skills................ 169

Case/Caseload Management............................. 211

Management of Grief.................................. 235

Community Resources.................................. 275

Alternatives to Institutionalization................. 319

Legislation Affecting the Older Adult................ 349

Protective Services for Adults....................... 393

Appendix A: Sample Evaluation Instrument............. 451

Appendix B: Journals Relevant to Aging............... 453

Appendix C: Organizations Relevant to Aging.......... 458

Appendix D: Addresses of Audiovisual Aids............ 464

CONTINUING EDUCATION PROJECT

The Continuing Education Project, School of Social Welfare, University at Albany, offers instructional programs for staff of state and local departments of social services and selected voluntary agencies. The project's target area for most programs is a 28-county region in northeastern New York; however, many programs are also conducted statewide. An integral part of the program is the development of instructional materials for use in project training activities and for staff development in local districts.

For the 1977-78 project year, training is conducted by five units: Adult Services, Income Maintenance/Medical Assistance, Child and Family Services, Planning and Needs Assessment, and Management and Staff Development. Instruction will be for 3,800 participants in 140 programs.

Project administrators and staff work in conjunction with training and program staff from the New York State Department of Social Services. Instructional materials, such as this publication, represent a product of this joint effort.

INTRODUCTION AND GENERAL TRAINING INSTRUCTIONS

- I. Introduction 3
  - A. Content of the Curriculum 4
  - B. Format of the Modules 4
    - 1. Training goal 5
    - 2. Objectives 5
    - 3. Outline 5
    - 4. Sample lecture 5
    - 5. Annotated bibliography 6
    - 6. Audiovisual aids 6
    - 7. Discussion questions 6
    - 8. Instructional strategies 7
    - 9. Pre-and post-knowledge questions 7
    - 10. Other 7
- II. General Training Instructions 8
  - A. The Trainer and the Trainees 8
  - B. The Training Session 9
    - 1. The physical environment 11
    - 2. Beginning the training session 12
    - 3. Closing training 14
- III. References 16
- IV. Supplementary Reading Material 17

I. INTRODUCTION

In recent years, there has been an increasing awareness of the magnitude of needs of the older adult. A consequence of this awareness has been increased funding of programs and services for the elderly. While this increased funding is an important step in meeting the needs of the elderly, problems still exist which can hinder the effective implementation and delivery of these programs and services. The problem is that although many social services staff have had experience with older adults, they have had little, if any, formal training in working with an older adult clientele.

The present curriculum has been developed in response to this need for training on the part of social services personnel. The purpose of the curriculum is two-fold. First, it provides content material in the basic concepts of gerontology and service delivery. Second, it is intended to generate self-awareness of attitudes toward the aged and the aging process. Designed specifically for use by Staff Development Coordinators of local departments of Social Services, the curriculum is based on training provided by the Adult Services component of the Continuing Education Project, School of Social Welfare, during the 1975-76 program year with modifications from the 1976-77 program. In addition to use by Staff Development Coordinators, the curriculum may also be useful for educators at the community college level, as well as for anyone else giving training in human services for elderly adults.

A. Content of the Curriculum

The model curriculum consists of 11 modules. Each topic covers at least one of three content areas: basic concepts of aging, casework skills, and specific issues in aging. It is felt that by providing information in each of these areas of content, the trainee should be able to develop skills and knowledge that will be highly valuable to him in facilitating casework with older adult clients.

The modules are arranged in an order that allows them to be used sequentially as part of a comprehensive training program. However, the format of each module is such that any of the topical areas can be covered by itself or in conjunction with any other module(s). While an effort has been made to minimize duplication of content, some information is relevant to more than one topic area and, thus, may be found in more than one module.

B. Format of the Modules

Each module is divided into several sections. These sections consist of goals and objectives for the module, along with a variety of learning resources. It is assumed that the trainer will pick and choose from, as well as supplement, the content of the modules in a way that will most effectively facilitate his training objectives.

The components of each module are described below.

Training goal. The training goal is the desired end result of the training program. It serves as a general guide for both the trainer and trainees as to the content area to be discussed. It is important that this goal be shared with trainees in order to justify their participation in the program. This can be accomplished by writing the goal on a blackboard or on a large sheet of newsprint that is visible to the entire group.

Objectives. In order to facilitate attainment of the training goal, a series of intermediate "steps" is listed. These are the "objectives" of the module. Two types of objectives are utilized throughout the curriculum. "Cognitive" objectives are designed to facilitate a change in knowledge and skills, while "affective" objectives are intended to produce a change in attitudes. The trainer should feel free to develop additional objectives as needed.

Outline. The outline serves two functions. First, it provides a summary of the topics that are included in the sample lecture. Second, it can serve as a starting point for the trainer who prefers to develop his own lecture material.

Sample lecture. Since the lecture method is the most frequently used training technique, a sample lecture has been included. The primary asset of the lecture method is that a large amount of cognitive content can be discussed in a relatively short period of time. While the lecture material is presented in a manner which makes it possible for the trainer to read verbatim from the module, it is recommended that the trainer prepare his own lecture, using the sample lecture as a model from which content can be derived. Each lecture concludes with a list of references that were utilized in its preparation.

In the module, "Interviewing and Communication Skills," it is important to note that for the sake of simplicity, the caseworker is referred to as "he," while the client is referred to as "she."

Annotated bibliography. In order to provide the trainer with sources of supplementary information on each topic, a bibliography of relevant books and articles is included. Since each reference is annotated, the reader is given some idea as to the content of the reference.

Audiovisual (AV) aids. A very popular method of instruction is the use of audiovisual resources. When used to supplement, rather than supplant other instructional methods, audiovisual aids can be quite valuable. Addresses of the various suppliers of these resources can be found in Appendix D.

Discussion questions. In order to stimulate further thought about feelings and attitudes toward the topic area on the part of the trainee, a series of Discussion Questions has been included. These questions can be covered in a small group setting, or they can be incorporated into the lecture.

Instructional strategies. In addition to the use of a lecture, discussion questions, and AV aids, several other techniques can facilitate learning on the part of the trainee. Some of these strategies include trips or visits, guest speakers, case studies, and role playing. The trainer needs to be able to determine which of these strategies will be most acceptable to a given group of participants.

Pre- and post-knowledge questions. Each module concludes with eight true-false questions about the lecture material. In order to determine whether the training has produced a change in knowledge, this test should be administered both prior to and at the conclusion of training. As the testing situation can be quite threatening to many persons, it is important for the trainer to point out that trainees are not being "judged" on the basis of their performance on the test.

Other. Some modules contain additional sections pertinent only to that module. Although consistency was strived for, it was felt that to exclude information purely for the sake of consistency was foolhardy.

Included among this category are the list of brochures and pamphlets found in the "Legislation" module, sources of information on death and dying in the "Management of Grief" module, and the "Supplementary Reading Material" sections that appear in several of the modules.

II. GENERAL TRAINING INSTRUCTIONS

A. The Trainer and the Trainees

The trainer can be said to be employing both skill and art. Skills are basic tools that can be learned and practiced. This manual provides the basic materials for honing the skills of the trainer's teaching efforts. However, training also involves an art, calling on the creative and imaginative capabilities of each trainer. The way in which this manual is used is up to the individual trainer.

Some persons may be better than others in a specific aspect of training; each trainer should find his own special strengths and utilize them as much as possible when beginning training. This is not to say that weak skills should not be used. Techniques with which the trainer may not initially feel comfortable can be introduced slowly and developed over time. Skills for the trainer to think about acquiring, if he does not already possess them, include asking questions, lecturing, leading discussion, leading role play, analyzing trainees' responses, leading exercises, handling conflicts, and summarizing.

A trainer cannot be expected to have answers to all questions. There is no shame in admitting, "I don't know." Problems can arise when a trainer, who will not admit that he does not know the answer, tries to "fake it." More often than not, this can lead to providing trainees with misinformation. This type of situation is much less desirable than simply not knowing the answer.

When the trainer does not have the answer to a question, he can turn the question to the audience for a response. If no one in the audience is able to answer the question, the trainer can volunteer to research the question or he can suggest that one or more participants volunteer to try to find an answer. This latter approach can turn what could be a frustrating situation for a trainer into a learning experience for trainees.

In utilizing different instructional strategies, the trainer should be aware of and responsive to the trainees' verbal and nonverbal responses. With any one group, some methods will fail while other methods will be highly successful. The trainer should be flexible in his approach and willing to change strategies to fit the group.

One of the first tasks of the trainer is to "set the stage" or make the trainees feel comfortable in the training setting. Disinterest, apathy, or anxiety should be dealt with at the very beginning of the training. If the trainer is open about the purpose of the training and the methods to be used, and if he conveys an enthusiasm for the subject matter, these problems should be overcome. Trainees should not be manipulated, forced into situations, or threatened. If the trainer can develop a sense of trust among group members, the learning process will be facilitated.

Training is usually offered to people in a group setting. Thus, it is important for the trainer to be aware of group dynamics. The trainer should understand how groups operate, how to lead groups, and the potential conflict between the group and the individual. The supplementary reading list at the conclusion of this section provides material useful for understanding group dynamics, leading group discussion, and conducting meetings.

The trainer needs to know the makeup of the group being trained. The trainer should consider the educational backgrounds of the trainees, why they are participating, what they already know about the subject, and what their work experiences have been. By understanding the audience and their needs, relevant instruction can be provided.

Although the needs of the agency may originally have been the impetus for assembling the group, the trainer might still wish to assess the trainees in order to ascertain the group's level and to select the most appropriate course content. This may be especially necessary and useful if trainees represent more than one agency. Training, for example, might be done with representatives from several county Departments of Social Services, or service workers from County Offices for Aging, Departments of Health, Departments of Mental Hygiene, Title VII Nutrition

Programs for the Elderly, or other local agencies working with the elderly (nursing home administrators, Salvation Army, etc.) This interorganizational approach serves to facilitate the establishment of linkages between community agencies which can later be useful in serving clients. The pre-test questions provided for each module could serve as a needs assessment. Later, in conjunction with the post-test, they will help to measure the extent to which training has produced change in knowledge, skills, and attitudes.

The trainer should be aware that there may be some resistance on the part of the trainees to the training process. Some trainees take a "show me" or "prove it" attitude. Resistance to change and opposition to new ideas are not unknown. With time and development of mutual trust, most trainees will drop these mechanisms.

B. The Training Session

The effectiveness of any training program is determined, to a greater or lesser extent, by how well the training session is planned and operated. Among the factors that can affect the quality of training are the physical setting in which the training takes place, as well as how the session is begun and terminated. The remainder of this section will examine some of these factors.

The physical environment. The physical setting has much to do with group comfort. The traditional classroom setting is not especially conducive to working with adults.

It is suggested that trainees be seated informally (e.g., around a cleared part of the room). The arrangement of the room should be such that all participants are able to see and hear what is going on. With this arrangement, it is easier to elicit participation from the entire group.

Beginning the training session. Most meetings or training sessions do not coalesce spontaneously. There are certain formalities which should be performed in order for training to get off to a good start. Several of these formalities need to be pointed out.

First, good preparation is essential. In addition to knowing the material thoroughly, the trainer should have all of the physical details worked out prior to the start of the meeting. This means that a sufficient number of chairs should be placed in a comfortable arrangement, room temperature should be adjusted to an appropriate level, audiovisual equipment should be set up, and arrangements should be made for someone to operate this equipment. As a reminder of needed materials for a training session, the following checklist might be helpful:

- Coffee and donuts (for breaks)
- Name tags
- Chalkboard, chalk, and eraser
- Extra pens or pencils and pads

- Handouts (e.g., articles, pre- and post-tests)
- Audiovisual equipment (if needed)

Second, introductions are a very important part of the training process. These introductions serve not only to allow the trainer and trainee to learn each other's names, but also to know more about each other as individuals and professionals. Some groups of trainees are comprised of people who know one another personally and/or professionally. In other situations, however, trainees will be from a variety of settings and may not know one another. Depending on the composition of the audience, introductions can be somewhat informal or rather elaborate. Time spent on this activity is well worthwhile, for it helps the participants develop into a cohesive group rather than remain as individuals in a group setting.

Third, the trainer needs to explain the rationale behind the training session. Persons who are involved in learning experiences deserve to have an explanation which justifies their participation in the training program. A clear statement of goals, objectives, and content of training can minimize confusion on the part of the trainees.

Fourth, confusion can be minimized by making sure that trainees are well informed as to the agenda for the program. The agenda can be posted on newsprint or distributed as a handout. While, for the most part, all sessions should begin and end on time, schedules should be flexible enough to allow extra time or, if the session has reached a good point of closure, an early dismissal.

Finally, the pre-test, if utilized, should be administered prior to the start of actual training. Sufficient time should be allowed for taking the test.

Closing training. In maximizing the value of a training session, an effective conclusion is of extreme importance. A good closing allows all participants the opportunity to understand the various, sometimes seemingly unrelated, components of the sessions as an entirety. One way to summarize what has been covered in training is to refer back to the objectives at the beginning of each module. Participants can discuss the extent to which they feel that these objectives have been achieved.

An essential part of training is evaluation. Generally, evaluation consists of two parts. The post-test allows the trainer to measure the actual amount of new information that the trainees have absorbed. The overall evaluation enables trainees to register likes and dislikes about the manner in which the training has been presented and whether or not it has been effective in meeting the training goals. Evaluation gives the trainer the opportunity to develop new learning experiences if objectives are not being met. As with the summary, the evaluation can be as simple or complex as the trainer wishes. Comments could be solicited from the group as a whole or a more complex instrument which allows the trainees to respond confidentially could be designed. An example of an evaluation form appears in Appendix A.

At the close of training it is very helpful to offer a thank you to participants who have given their time and energy to the training session. So often, the words "thank you" are overlooked. A simple thank you can have a highly positive impact on a trainee.

III. REFERENCES

Curry, R. Training guide for trainers. (One of a series of publications developed for the Nutrition Program for the Elderly by the Community Nutrition Institute.) Washington, D.C., 1975.

Ingalls, J. D. A trainers' guide to andragogy. H.E.W. Social and Rehabilitation Services, 1973.

Piluras, C. How to plan better meetings and training programs. (Prepared for the Office of Economic Opportunity by the National Council on the Aging.) Washington, D.C., 1972.

IV. SUPPLEMENTARY READING MATERIAL

Bradford, L. P. *Group development*. LaJolla, Ca.: University Associates, 1974.

Doyle, M., & Strauss, D. *How to make meetings work*. Ridgefield, Ct.: Wyden Books, 1976.

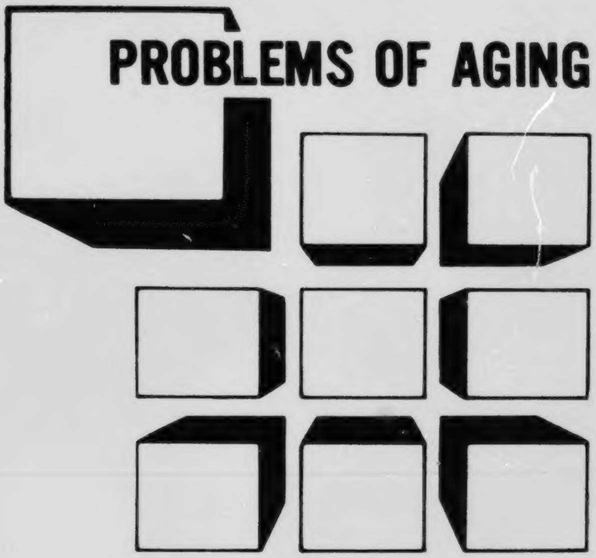
Napier, R., & Girschenfeld, M. *Groups: Theory and experience*. Boston: Houghton Mifflin, 1973.

Olmsted, M. *The small group*. New York: Random House, 1959.

Pfeiffer, J. W., & Jones, J. (Eds.). *The annual handbook for group facilitators*. LaJolla, Ca.: University Associates, 1972.

Shaw, M. *Group dynamics: The psychology of small group behavior*. New York: McGraw-Hill, 1971.

PROBLEMS OF AGING



I. Training Goal 21

II. Cognitive Objectives 21

III. Affective Objectives 21

IV. Outline 22

V. Sample Lecture 23

VI. Annotated Bibliography 49

- A. Books 49
- B. Periodicals 51

VII. Supplementary Reading Material 53

VIII. Audiovisual Aids 54

IX. Discussion Questions 57

X. Instructional Strategies 58

XI. Pre-and Post-Knowledge Questions/Key 59

I. TRAINING GOAL

To develop an understanding of some of the types of problems that beset the elderly in everyday life. To see how, through life span planning, services to the elderly might be useful in eliminating or minimizing these problems.

II. COGNITIVE OBJECTIVES

- identify the demographic trends which are intensifying problems among the elderly population and the effects of these trends upon the service delivery system
- list some of the pros and cons of mandatory retirement and understand the relationship between retirement and poverty among the elderly
- demonstrate that while problems such as low income, poor housing, inadequate medical care, and lack of adequate transportation are problems which plague society in general, the elderly are particularly vulnerable to these conditions
- describe health care for the elderly in terms of the nature of the need for services and the expense of medical care
- differentiate between the types of coverage provided by Medicare and Medicaid

III. AFFECTIVE OBJECTIVES

- develop an awareness and acceptance of one's own aging process
- understand that many of the basic problems faced by persons of all ages are greatly magnified when multiplied by the factor of increasing age
- become aware of the quality of life of older individuals in our present society
- develop an understanding of how problems such as decreased income, declining health, inadequate housing, and lack of mobility frequently contribute to the loneliness and isolation of the elderly
- replace negative, unfavorable attitudes toward aging and the aged with a more positive, constructive point of view

IV. OUTLINE

A. Introduction

B. Demography

1. Increased numbers
2. The old-old
3. Increased life expectancy

C. Income

1. Retirement
2. Social Security
3. Supplemental Security Income

D. Health Care

1. The medical model
2. Medicare and Medicaid

E. Mobility and Transportation

F. Housing

G. Triple Jeopardy: The Minority Aged

H. Ageism

I. Services to the Elderly Through Life Span Planning

J. Social Action Among the Aged

K. References

V. SAMPLE LECTURE

A. Introduction

Although problems may occur at any time during the life cycle, there are two major types which occur in the later years. The first type encompasses those psychosocial problems of adjustment inherent in the aging process. While formerly this problem of adaptation to continuing change was thought to be the "disease of aging," it is now recognized that aging is a developmental process. Consequently, these psychosocial problems are discussed in the module "Processes of Aging."

The second set, the social problems of low income, poor housing, inadequate medical care, inadequate transportation, and so on, are really part of the societal problem of providing decent living conditions for all citizens. Everyone, not only the older person, needs to be secure, to continue to be active, and to be treated with respect. It does appear, however, that as they age, persons become increasingly vulnerable to these conditions. Consequently, while a lower standard of living is not intrinsic to the aging process, but rather, results from inadequate social welfare provision and since so many elderly fall victim to a diminished standard of living, these issues will be dealt with here as problems of aging.

B. Demography

To fully understand the problems of aging, it is important to begin with a brief discussion of demography. Only by understanding recent population changes can we begin to see why the problems of the aged are, to a substantial degree, a consequence of our modern age. Since the turn of the century there are basically two demographic trends which have influenced service delivery to older persons and, because they are thought to be permanent trends, may have an impact upon our entire societal structure, causing us to redesign our living environments; to restructure our systems of education, work and retirement; and to redefine systems of income maintenance and human service delivery as well.

First, there has been a significant increase in the life expectancy of individuals, especially the life expectancy of women. Second, there has been a decided increase in the aged population, both in total numbers and as a proportion of the total population. Both trends need to be examined as to their causes and, in some cases, their dual effect.

1. Increased numbers

Let us examine first the trend toward overall increase in the aged population group--those persons aged 65 or over. As recorded in the 1970 census, the aged population numbered approximately 20 million individuals, or about 10% of the overall population. This compares with 3 million aged persons, or 4% of the population in 1900. The major reasons for this increase were: a) decrease and control of infectious and parasitic disease, such as tuberculosis, influenza, and pneumonia, which were major killers at the turn of the century; b) advances in public health and sanitation, better food and methods of food storage, better health care and technical advances of medical science, and better living environments; c) decline in the birth rate due to industrialization and urbanization; and finally d) decline in death rate not only at the upper age levels, but also the drastic decline in mortality of children. This decline allows individuals who survive infancy and childhood to grow to adulthood and, coupled with the other factors, most likely to live to old age. In 1900, children (15 years and younger) represented 53% of the deaths each year. Today they represent only 6% of the deaths. This decline can be attributed to substantial improvements in maternal care (pre/post natal) and better early childhood care, both of which came about through advances in public health.

This demographic trend appears to be a worldwide phenomenon which accompanies industrialization. A table of the world's populations, reported by the United Nations in 1971, divides the world's nations into four categories--young, youthful, mature, and aged, according to the proportion of 65+ in their population. Those countries which experienced industrialization earliest, such as East Germany (15.5%), West Germany (12.6%), and England (12.4%), have the greatest proportions of older people. The United States was categorized as "mature," and the countries of the "Third World" fell into the categories of young and youthful.

2. The old-old

Even more important to note when looking at the rise in the number of older persons is that not all the population group 65+ is increasing at the same rate. Within the population group over 65, one-half are 73 and over, and 6% or one million are 85+. This older group (73+) is expanding the fastest in proportion to any other age group so that, although we may say that old people are living longer and are healthier to a later age, the increase in the upper age limits is going to have a significant effect on service delivery, such as utilization of nursing homes. Ten years ago, the average age of nursing home residents was about 70, and it was not unusual for residents to enter these homes in their middle to late 60s. Today the average age of nursing home residents is 82. It appears old people are staying healthy and remaining in the community longer. Therefore, based upon the estimates that 20% of the elderly will receive institutional-based services at some point in their life, and upon the fact that the upper age groups of elderly are expanding the fastest, one might predict a sustained, if not increased, demand from this group for services.

3. Increased life expectancy

Increased life expectancy, the essential factor in the overall growth in population, is due primarily to increased maternal and early childhood care (delivered through the public health model). Life expectancy in the United States has grown from 47 in 1900 to 71.5 today. This figure represents an average between the life expectancy for men, which is 67.6, and women, which is 75.3.

The United States has, to some extent, fallen behind other industrialized nations in increasing its life expectancy due to greater infant mortality; the number of infant deaths in the United States is significantly higher than many of the European, particularly the Scandanavian, countries. In Norway the average life expectancy for a baby girl at birth is 78 years, which of course means that one-half will live much longer; Sweden and the Netherlands are very close to Norway in this regard.

A discussion of life expectancy would not be complete without mention of the significant difference between the greater life expectancy of women than of men. There are a few possible explanations for this difference; however, authorities on the subject are not in agreement. One theory holds that the greater longevity of women is linked genetically to female hormones which appear to help keep women's blood from clotting as easily as men's, thereby preventing heart attacks, the major killer of men (especially in middle years).

Furthermore, women have received the most benefit from modified health practices. Whereas in the 18th and 19th centuries many men outlived several wives because women died in childbirth, women today are expected to outlive men by about eight years. Regardless of the reasons, aged women outnumber men by about 3 to 2 at age 65 and this proportion continues to increase in later years.

This number of aged (and oftentimes widowed) women has implications for service delivery. Today's older women are least likely to have employment experience and thus may undergo many of the problems which accompany low incomes; also, they may be unfamiliar with financial management. The special needs of elderly women, therefore, cannot be overlooked.

Another interesting aspect of life expectancy trends in the United States is the difference in the longevity of whites and nonwhites. Though the life expectancy for nonwhites has approximately doubled since 1900, a nonwhite person can expect to live, on the average, about seven years less than a white person.

Since, as mentioned before, demographers believe both of these population trends - increased longevity and the overall "aging" of society as a whole - to be a permanent trend, the proportion of old people will continue to grow and is now expected to reach 1[illegible].1% in the United States by the year 2000. In 2010, as the post World War II baby boom reaches old age, this proportion is expected to reach 20%. Throughout each of the problem areas to be discussed, it is important to keep in mind that these demographics are already beginning to have an impact upon each of the service systems designed to provide for their relief.

D. Income

On the average, the median income of old people is 1/2 to 2/3 less than that of younger households. The average income of households headed by persons under 65 years of age is $13,532, whereas of those households with heads 65+, the income is $5,585. Over 20 percent of New York State's aged fall under federal poverty standards, which is $2,572 for individuals and $3,232 for couples. Although the aged comprise about one in ten of the general population, the aged represent one in five of those living below the poverty level.

1. Retirement

The major reason for the drastic drop in income for those 65+ is retirement. About one-third of the labor force is currently working under some policy of formal mandatory retirement. Additionally, there are numerous subtle methods of forcing people out of the labor force as they become older. Since median income of the elderly who continue to work is over twice as high as those who are not employed, it is clear that the advent of retirement all too often means the advent of poverty.

Perhaps the greatest injustice of mandatory retirement is its arbitrariness. Age 65 is considered, in most cases, the "appropriate" time to be released from all responsibility in the labor force. There are no biological nor psychological reasons for this chronological age "dividing line" and certainly, as we have seen through demographic trends, it is an antiquated notion. Older persons are leading healthy and active lives far past age 65. Norway recently raised its retirement age to 70 partly because of the greater functioning capacity of this group and partly in response to the increase in the proportion of the aged in the population. It is felt that these older workers are needed in order to continue to provide a productive economy. In the United States, however, particularly when unemployment has been high, the retirement age has been lowered, and pressures to remove older workers from the labor force are many.

What, then, are the major sources of income for older persons after retirement? Savings and/or other investments, pension plans, and Social Security/SSI are the chief contributors. Because most clients will be receiving income solely from the last category, these two programs warrant brief discussion. (Also see the module entitled "Legislation Affecting the Older Adult.")

2. Social Security

The Social Security Act of 1935 established a public policy toward income protection and security for two main groups: the aged, and widows and children of active members of the work force. The program was intended to supplement savings and pensions in old age. It was not conceived as the sole means of support in retirement. It is here, however, that the first flaw in the system becomes apparent. In modern society savings are often eaten up by inflation, and the wages of lower income groups are spent on necessities such as food and rent, with little being set aside for savings. In addition, because employers who contributed to Social Security funds believed their contributions to be sufficient, private pension plans did not grow in the manner expected and, therefore, today less than 1/4 of older workers are covered by any pension plan other than Social Security.

A further problem of Social Security is that it is an insurance plan paid into by employers and employees and the benefits received are based entirely on the amount of employment the worker has had. Therefore, if his work pattern has been sporadic and/or at a low wage, this will be reflected in the Social Security check. Also, because Social Security is an insurance fund and not paid out of general revenues, the financing of the fund fluctuates with the number of contributors in the work force at any given time. In time of high unemployment and large numbers of retired persons, the fund may become depleted unless a remedy can be found.

3. Supplemental Security Income

During the 1970s, the Supplemental Security Income (SSI) program was added to provide a minimum income to the poorest of the poor - those who were not receiving Social Security benefits or who were receiving very low payments. The problems of this program are many. One problem is that SSI is a flat grant program in which the amount is based solely on sources of income and living arrangements with no provisions for emergency assistance or special need grants. Another problem is that the program is administered by an agency (Social Security Administration) which does not provide services. The sole purpose of the agency is to establish eligibility and issue checks; employees of the agency are often not trained to make referrals and, consequently, the needs of many older persons are neglected or lost in the shuffle between those agencies providing income and those providing services.

A shortcoming of both SSI and Social Security benefits is the disincentive to the recipient to seek other sources of income. SSI has eligibility requirements that prohibit benefits the moment other resources rise above a subsistence level. Social Security benefits are tied to what has become commonly described as "the retirement test." This requirement holds that a beneficiary must be fully retired in order to receive full benefits of the program. Currently, an older person (until age 72) can only make $3,000 from part-time employment without being penalized by a reduction in the Social Security check, even though Social Security is an insurance program designed to pay benefits to those who have contributed throughout their work history.

It is clear, then, that the problems of income in the later years are primarily those of closing avenues for seeking income through the labor force and the inadequacy of income support systems in old age (Social Security/SSI). Generally, just because a person reaches age 65 that person is expected to live on a greatly diminished income while the expenses of daily living do not similarly diminish; food, rent, clothing, the necessities of life, remain the same or increase. Medical costs in particular tend to increase significantly with age.

D. Health Care

A discussion of health care problems of the aged is best begun with a look at costs. On the average, old people pay three times more for health care than their younger counterparts. The average annual cost per person 75+ is $1,360 as compared with $472 for persons 19-64. The aged consume 25% of all drugs and make up 30% of the total National Health Care expenditures each year.

The health problems of the aged, as a group, are those related to normal age-related decrease in functioning capacities, such as loss of hearing and eyesight and such chronic diseases as arthritis, heart disease, and high blood pressure. Eighty-six percent of the elderly suffer from one or more chronic disease; 18% of those are seriously hampered in their mobility due to these diseases.

An analysis of the above information provides the two most significant problems with regard to health and health care of the aged. The first is the nature of the need for medical services; that is, medical services which respond to debilitated functioning capacities and chronic care. The second is the expense of medical care provided to persons with substantially inadequate incomes and resources.

1. The medical model

The first problematic issue with regard to health care has to do with what is commonly known as the medical model of health care delivery. The medical model is designed to cope with disease entities, acute care, and "cures" for illness. Medical research, medical education, and the practice of the majority of those in the health care system are organized around these concepts. One can see, given this model, how the needs of the elderly are neglected. Physicians are reluctant to take an older person with little hope of cure as a patient. Older persons whose needs may be for supportive health care services, best offered at home or on an outpatient basis, may find the medical-hospital-institutional model to be the only available service.

2. Medicare and Medicaid

The second problem, that of expense, is also closely related to the problems inherent in the medical model. The two major public funding sources for health care for the elderly are Medicare and Medicaid. Medicare is a health insurance plan only for subscribers over 65, while Medicaid is a health insurance plan for those of any age who are income eligible. Despite common misconceptions about the extent of coverage provided by Medicare, the program actually covers only 38% of the health care costs of the elderly. Due to a number of restrictions imposed since the beginning of the program in the mid-1960s, the coverage of Medicare has decreased sharply, both because of services excluded and the copayments and deductibles exacted from the elderly.

Medicare offers no coverage for preventive health care, such as a yearly physical examination, nor does it cover chronic illnesses, despite the fact that chronic illness affects almost 90% of older persons.

Medicare will not pay for eyeglasses, although 92% of the elderly need glasses. Medicare does not cover dental expenses, nor will it reimburse for the cost of out-of-hospital prescription drugs, which on the average cost the aged $118 per year.

Medicaid does pick up some of the costs excluded under Medicare - only, however, if the person is medically indigent. Medicaid does reimburse for long-term care of the elderly. This has had the dual effect of inflating the cost of care, with little regard for the quality or appropriateness of such care, while at the same time providing more or less open funding for institutionalization of old people with no look at community alternatives. The Medicaid system is now being closely scrutinized at both the state and federal levels because of the tremendous amounts of spending with few safeguards against fraud and little regard for the best quality care for the recipients.

The solutions to these interrelated problems of health and health care for the aged may be found in the Public Health model that furthered the prolongation of life and, hence, created this elderly group. A model of service delivery which supports basic areas of functioning rather than an all-out attempt at cure is necessary in the later years. Services delivered in homes or easily accessible in neighborhoods, along with a greater emphasis on relief from chronic illness and its effects, are needed at prices which the elderly can afford.

E. Mobility and Transportation

One of the most prevalent concerns of the older person is, quite simply, the ability to "get around." Difficulties regarding mobility and lack of adequate transportation facilities combine to confine many of the elderly to a very small life space.

The mobility of older adults is hindered by an age-related decline in sensorimotor functioning. Vision, for example, begins to diminish somewhere in the 40s to the 50s, stabilizing after the 50s. At the same time, the older individual is experiencing a decline in motor performance; he cannot move as fast, walk as far, or react as quickly to a potentially dangerous situation as he could when he was younger. When these normal, age-related changes are considered as an entirety, it becomes easy to understand how mobility can be such a great problem for the elderly. (For a more detailed discussion of the sensorimotor losses which accompany advancing age, refer to the module "Processes of Aging.")

The problem of mobility in order to acquire services or to carry out normal daily activity is more easily appreciated when one can realize that our environment has not been designed to support the limited capacities of the older adult. Instead of designing our environment to support diminishing capacities which eventually most of us will face, our buildings and roads have been designed for the young, healthy individual.

An example of such design is to be found in observing traffic lights. Increasingly, there is a trend to design city streets with three, four, five, or even six lanes of traffic moving in the same direction, with traffic lights timed to move the automobile at an optimal speed. Little concern is given to the pedestrian who needs to fight the traffic in order to cross the street. When combined with diminished sensorimotor capacities, the function of crossing a busy street becomes especially dangerous. This is accentuated by statistics which show that the highest proportion of pedestrian deaths occurs among the elderly.

Transportation problems exist with every service group and can sometimes be a major stumbling block to self-sufficiency and well-being for a client. Some services, such as Title XIX (Medicaid) and Title VII (Nutrition Program), furnish transportation or provide reimbursement for such costs. However, when transportation does not exist, particularly in rural areas, community organization efforts and a hard look at the allocation of resources may be necessary. It may be possible to organize volunteers to provide transportation services or for a number of agencies to pool resources for the use of a school bus for certain hours each day.

Inadequate transportation is a concern for the elderly in both rural and urban areas. In rural areas, there is a lack of mass transit facilities. Additionally, since rural houses tend to be spread over a geographically larger area than urban houses, the potential for isolation is much greater. While most urban areas have some form of mass transportation, the rapid pace of such facilities often makes the system inaccessible for those aged persons who suffer from sensorimotor losses and/or chronic illness of some form.

A possible solution to the problems of transportation and mobility as they pertain to the elderly lies in community organization, where an attempt is made to plan cities and services to be accessible to all people. Transportation is a necessary element in the effort to provide adequate services. The needs of the aged client may be no different from the rest of the population, except for the normal diminished capacities that often accompany aging.

F. Housing

It is difficult to determine how large the problem is regarding adequate housing for the elderly. There are, however, several areas that can be easily cited. The first is that the elderly frequently live in neighborhoods that have deteriorated in recent years. These may be in older areas of cities or in rural farming areas that had previously contained self-sufficient farms. In both cases, the elderly have remained as survivors in areas left by familiar friends. What is often left to them is, at best, isolation and, at worst, fear and violence.

Older persons who own their own homes face an additional difficulty. Some 46% of elderly New Yorkers are homeowners. This may appear to be a sign of economic well-being; however, home ownership makes these people particularly vulnerable to increased costs in running a home. The cost of fuel oil, for example, has risen by 110% from 1970-75. Similarly, the cost of other fuels, taxes, and home repairs has risen substantially.

A trend in the 1960s and early 1970s toward senior citizen high-rise apartments, in which older persons could live together in what was looked at as "specialized" housing to meet their needs, did not entirely ameliorate the situation. Several problems with this type of housing include the fact that such units were often built in high crime areas. Also, the high rise was a totally new environment for many older people who very often received no supportive services to help in the adjustment process. A third serious problem is that in many instances old people don't want to live solely with other old people, but rather, find the age-integrated mix of their old neighborhoods much more compatible. This does not mean that high-rise housing should be abandoned, but rather, that finding and maintaining good housing for any individual should involve a good assessment of what the particular needs and desires of the person are. This is in no way changed merely because the individual is elderly. Inherent is a matter of choices - alternative life styles from which to choose - in the same manner that living patterns are chosen earlier in life.

G. Triple Jeopardy: The Minority Aged

The basic problems of aging, such as those which have been discussed throughout this section, are problems which, to a varying extent, plague most older individuals. An older person who is a member of a racial minority has additional burdens. This person is frequently subjected to discriminatory behavior not only because of age, but also because of race. The term "triple jeopardy" is sometimes used to depict those economically disadvantaged older persons whose situation is further hindered by membership in a racial minority group.

An example of the type of age-related problem which is multiplied by minority group membership is a lack of adequate income. Many elderly blacks, for instance, are not eligible for retirement program benefits, either by reason of a transient work history or by reason of having worked at jobs where no retirement policy existed. Also, as a result of the shorter life expectancy of blacks and other minorities, such people will tend to have fewer years of eligibility for Social Security. A consequence of this lack of adequate income is that 10 to 20 percent more elderly blacks are active in the work force than elderly whites.

It appears doubtful that this trend will change until blacks and other minorities are given equal opportunities for career development.

Another problem which hinders service delivery to minority elderly is the linguistic and cultural barrier between middle-class white service providers and elderly minority group members.

In order to provide meaningful services to older minority group members, it is first necessary to minimize the effects of racial discrimination and to work to alleviate the communication gap. Only then will it be possible to deal effectively with the problems of aging among minority groups.

H. Ageism

Another problem to be discussed in this unit, ageism, is perhaps the most difficult problem faced by older persons because it is insidious and has become institutionalized in numerous policies and practices. Coined by Robert Butler in 1968, the term "ageism" refers to a prejudice against the elderly which is a result of stereotypes and myths about old people and the process of growing old.

Ageism is a cruel by-product of both the knowledge explosion (educational and technical advances, primarily since World War II) and the rapid rate of change which occurs in our modern society. In previous generations, when change took place at a much slower pace and when few mechanisms existed for the transmittal of information from one generation to the next, old people served as repositories of knowledge. Today, however, old people are looked upon as being informationally and, therefore, socially obsolete. An unfortunate consequence of ageism is that many older people fall victim to the "self-fulfilling prophecy," whereby they are reinforced to adhere to the myths and stereotypes and eventually come to accept such misconceptions as fact.

In order to reverse the trend toward ageism, it is necessary to replace negative, stereotyped attitudes with factual information which accentuates the positive aspects of aging. The first step in the reduction and eventual elimination of ageism is to reintegrate the older person into the mainstream of society. We are faced, therefore, with the challenge of finding and defining new roles for older people - roles that will be accepted by persons of all ages with dignity, equality, and respect.

I. Services to the Elderly Through Life Span Planning

As we have seen, the problems of aging are interrelated and multifaceted. Solutions, therefore, will lie both within the system of service delivery and in our attitudes and previously devised schemes of problem solving. The problems, if not addressed system-wide, will only become more prevalent. Moving toward solution of the problems of the aged, we can find solutions that will benefit us all.

As discussed in the "Processes of Aging" module, aging can be seen as developmental. Just as an infant has special needs at that stage of life, so too does the older person. We have seen throughout each problem area discussed that problems arise when the particular needs of the older person are not met. For example, our environments are not designed to promote access by the elderly and do not accommodate for normal age-related losses. Also, much of our service structure in health, mental health, and social services is primarily aimed at the young or the near young. Whereas improved public health and maternal and child care services have had their effect at promoting and prolonging life, they have fallen short at providing adequate support in later years.

If current population trends continue, there will be a shift in the so-called dependent population (that part of the population that does not work) from the young to the old. It is necessary, then, to think about a shift of resources and new methodologies. Services will need to be made more accessible, available, and relevant to older people and will need to center on promotion of functioning.

Too often, old people are thought of as inevitably dependent. In a society that values independence so highly, this is perhaps the most serious of all indictments. In reality, who is truly independent? Each of us depends in some way on others to do certain jobs and all the things associated with our lives. This is what we must remember in dealing with older adults and in planning service delivery - that as human beings we all need systems of social supports. In essence, we need an interdependence throughout the life span. Support from others and encouragement of the participation of old people in this relationship is necessary.

Planning services to meet the various needs of the latter part of the life span, therefore, involves integrating what we know about aging and human development and translating it into services. It is important to note that with advancing age, the need for new services overlaps the continued need for services which have been initiated at an earlier time. Along with devising appropriate services, the task of the helping professions must be to continue to add new modes of service delivery. In order for services to be effective, they must be accessible to the life styles of those receiving services. Neighborhood multi-service centers, where nutritional meals, health screening, and other services are available, may become the more effective means of service delivery; or there may be new methods as yet undevised.

While these systemic changes may seem a part of the distant future, there are several indications of movement in this direction:

1) Population trends - if those 55+ are included in the older age group, they would comprise 15% of the population now, and they are the fastest growing of all age groups.

2) The next generation of old people will be better educated and be of better health to an older age compared with the elderly of today who have an average education level of 8th grade (and who often struggle with language barriers).

3) The next generation of the aged will be accustomed to a higher standard of living and will have a familiarity with government support systems; old stereotypes against government interference will be weakened.

4) As a client group, the new elderly will be better able to articulate their needs and to move through the system to accommodate their needs through political and other means.

J. Social Action Among the Aged

In addition to the above indicators, an impetus for increased and innovative services for the elderly lies in the mobilization of the aged themselves. We see some evidence of this movement evolving today.

The American Association of Retired Persons (AARP), which grew out of the National Association of Retired Teachers, now has 8 million members. In New York State, a Senior Citizens Action Council (SCAC) has branches in many locations, and its members testify before legislative bodies, act as a pressure group and have obtained senior citizen discounts on consumer goods, etc. Gray Panthers, started in the early 1970s, has been active in fighting all forms of discrimination and in promoting reeducation and in revitalizing the image of older persons.

Old people do have many obstacles in their struggle to maintain a place in society and to meet their basic needs. It is the responsibility of service providers to help remove these obstacles and support their desired goals.

K. References

Atchley, R. C. The social forces in later life (2nd ed.). Belmont, Ca: Wadsworth, 1977.

Beattie, W. M., Jr. A conceptual framework for developing policy on aging. Seminar presented at the Advocacy Leadership Roles of State Agencies on Aging Training Program, 1975.

Butler, R. N. Why survive? Being old in America. New York: Harper & Row, 1975.

Cowgill, D. O. The aging populations and societies. Annals of the American Academy of Political and Social Science, 1974, 415, September, 1-18.

Glasse, L. Status of the aging: Older New Yorkers in 1976. New York State Office for the Aging, 1976.

Glasse, L. Testimony before a hearing on mandatory retirement conducted by the Assembly Committee on Aging, January 21, 1977.

Hendricks, J., & Hendricks, C. D. Aging in mass society: Myths and realities. Cambridge, Ma: Winthrop, 1977.

Manney, J. D. Aging in American society. Institute of Gerontology, The University of Michigan/Wayne State University. Published under grant #SRS-HEW-94-P-76007/5-01, Project TAP (Training Area Planners), 1974.

Patent, J. Rural transportation demonstration project: A report. New York State Department of Social Services, 1976.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Atchley, R. C. The social forces in later life (2nd ed.). Belmont, Ca.: Wadsworth, 1977.

This text provides a thorough introduction to the topic of social gerontology. Among the topics covered are health, retirement, finances, dependency, and the roles and functions of the elderly with regard to the economy, government, and community. An extensive reference section is included.

Busse, E. W., & Pfeiffer, E. (Eds.). Mental illness in later life. Washington, D.C.: American Psychiatric Association, 1973.

Although written primarily for physicians and health professionals, this book examines the field of mental health in aging, clarifying many areas of misconception. The second part of the book is in question/answer format, and explores many questions about senility, brain functioning, longevity, and treatment and rehabilitation.

Butler, R. N. Why survive? Being old in America. New York: Harper and Row, 1975.

The author of this Pulitzer Prize winning book examines the plight of the elderly in relation to poverty, pensions, right to work, housing, medical care, mental illness, nursing homes, and politics.

Gochas, H., & Gochas, J. (Eds.). The sexually oppressed. New York: Association Press, 1977.

This book deals with the associated problems of various subgroups in our population among whom sexual relations are generally not approved. Noted authorities in sexuality and sexual functioning, as well as in gerontology, have contributed to the book's chapters. Of the twenty chapters, several are singled out as of primary interest for the professional in gerontology; "Black Widows," "The Aged," "The Aging Male Homosexual," "The Institutionalized," "The Physically Handicapped," and "The Terminally Ill."

Kalish, R. A. (Ed.). The later years: Social applications of gerontology. Monterey, Ca.: Brooks/Cole Publishing Company, 1977.

This book focuses on what is called social gerontology or, more specifically perhaps, applied social gerontology. The book is intended primarily for those people who will be working with the elderly by providing direct services, by initiating and developing programs, by planning, and by developing policy. The content area is richly varied with new approaches and literature presented in all areas, including aging and ethnicity; the psychosocial view; the economic status of the aged; the retirement years; health, politics and law; the familial relationship; the physical life space of the elderly; social and health services; and the institutionalized older person.

Kart, C. S., & Manard, B. B. (Eds.). Aging in America: Readings in social gerontology. Port Washington, N.Y.: Alfred, 1976.

This book of readings provides a good cross-section of many of the salient problems of aging, including theory, methodology, demography, biological and psychological aspects of aging, retirement and leisure, living environments, institutionalization, and death and dying. A good reference to supplement either a lecture or a more general text.

Loether, H. J. Problems of aging: Sociological and social psychological perspectives. Belmont, Ca.: Dickenson Publishing Company, 1975.

This book was originally written to fill the need for a short survey of the problems of aging from both the sociological and social psychological perspectives. The intent is to present an overview of the most pressing problems associated with the aging process. Included in this overview is: the aging process as a problem, changing family and community roles, mental and physical health of old people, economic and social aspects of housing problems, employment patterns among older workers, widowhood, death, and exploitation of the aged.

Vedder, C. B. Gerontology: A book of readings. Springfield, Ill.: Thomas, 1963.

The selections presented in this large volume are largely based upon empirical research. This book serves as a convenient compendium for the professional wishing to know more about various aspects of aging: development of gerontology, sociology of aging, demographic characteristics, economic aspects, health problems, religion, recreation, politics and crime, and community responsibility and research.

B. Periodicals

Brotman, H. B. Income and poverty in the older population in 1975. Gerontologist, 1977, 17(1), 23-26.

This article presents a statistical overview of the fact that older Americans have experienced a slight improvement in their current economic position while conforming to the longtime trend of having only about half the income of younger Americans.

Butler, R. N. Psychiatry and the elderly: An overview. The American Journal of Psychiatry. 1975, 132(9), 893-900.

This article presents the current state of psychiatric services for and attitudes about the aged. It deals with the rationale of ageism, proposes several alternatives to institutionalization, and offers several examples of therapy done to reverse the "onset of senility."

Kosberg, J., & Harris, A. Attitudes toward elderly clients. Paper presented at 29th Annual Scientific Meeting of the Gerontological Society, October, 1976.

This article discusses the notion that, although the elderly increasingly occupy a position as a client group of medical and mental health care professionals, the attitudes of professionals toward the geriatric client tend to be negative. It is emphasized that professional training in gerontology might help to reorient the professional's view of the elderly client to a more positive image.

Shanas, E. The aged report on their health problems. In A. J. Simon & L. J. Epstein (Eds.), Aging in modern society. Psychiatric Research Report of the American Psychiatric Association, 1968, 23, 56-63.

This paper is concerned with the impact that attitude has on the functioning levels of aged individuals. It states that if a person, for example, feels himself to be in poor health, a health pessimist as classified by Shanas, the individual may tend to function on a lower level than an individual who medically may in fact be in poor health but who maintains a positive attitude toward their health. The latter situation classifies an individual as a health optimist, according to Shanas.

Simos, B. Adult children and their aging parents. Social Work, 1973, 18(3), 78-85.

This paper examines the relationship of Jewish-American adult children to aging parents. It found these children were involved in helping their aged parents cope with a wide range of problems: social and housing problems, transportation and recreation problems, financial difficulties, and loneliness and grief. Although the study dealt with a specific ethnic group, the author believes the findings have implications for social work with all aged persons.

VII. SUPPLEMENTARY READING MATERIAL

Barbeau, A. Retirement and leisure participation: Continuity or crisis. *Gerontologist*, 1973, *1*(1), 29-32.

Brennan, M. J. *The economics of age*. New York: W. W. Norton, 1967.

Butler, R. N., & Lewis, M. *Aging and mental health*. St. Louis: C. V. Mosley Co., 1973.

Havighurst, R. J., & Albrecht, R. *Older people*. New York: Longmans, Green & Co., 1953.

Hoffman, A. M. *The daily needs and interests of older people*. Springfield, Ill.: Thomas, 1974.

Jackson, J. J. The blacklands of gerontology. *Aging and Human Development*, 1971, *2*(3), 156-171.

Kreps, J. M. *Employment, income and retirement problems of the aged*. Durham, North Carolina: Duke University Press, 1963.

Masters, W. E., & Johnson, V. E. Human sexual response of the aging female and aging male. In B. Neugarten (Ed.), *Middle age and aging*, Chicago: University of Chicago Press, 1968.

United States Government. *Demographic and economic characteristics of the aged*. (1968 Social Security Survey) Washington, D.C.: U.S. Department of Health, Education and Welfare, Office of Research and Statistics, (Report No. 45). (DHEW Publishing No. (SSA) 75-11802), 1975.

VIII. AUDIOVISUAL AIDS

ATTENTION MUST BE PAID

16mm film/Color
27 minutes, 1976
Available from: The Media Guild
Rental : $ 35.00
Purchase: 365.00

The problems faced by aging individuals in our society is the main theme of this very well produced film. Their everyday struggle to cope with increasingly hard to handle medical, financial, familial, and emotional problems is depicted in this forthright and thought-provoking film.

BEYOND SHELTER - IDEAS ON HOUSING FOR THE ELDERLY

16mm film & video cassette/Color
25 minutes, 1975
Available from: Transit Media
Rental : $25.00
Purchase: 375.00
250.00 video cassette

Denmark has long been noted for providing a meaningful social climate for its older citizens. This film, interspersed with black and white segments of life in a nursing home in North America, shows some of the types of housing which are designed to keep the older Dane out of the institutional setting for as long as possible. The film can be useful to supplement a discussion of living environments for the older adult.

I THINK THEY CALL HIM JOHN

16mm film/Black & White
26 minutes, 1970
Available from: Mass Media Ministries
Rental : $ 17.50
Purchase: 175.00

One drab, lonely Sunday in the life of an old miner, a widower on pension and without children and close friends, gives evidence of retired life for so many of the clients seen by caseworkers. This documentary film has sparse but incisive narration.

A MATTER OF INDIFFERENCE

16mm film/Black & White
45 minutes, 1976
Available from: Phoenix Films, Inc.
Rental : $ 50.00
Purchase: 400.00

This film is an investigative documentary on aging. It is a critique of our society's ambivalence toward its aged. Identity, loss of social status, the nuclear family, sexuality, death, and social action are among the topics discussed by, among others, Maggie Kuhn, founder of the Gray Panther Movement.

MR. STORY

16mm film/Color
28 minutes, 1976
Available from: Phoenix Films, Inc.
Rental : $ 35.00
Purchase: 350.00

Mr. Albert Story describes his life and attitudes with a captivating forthrightness that so often characterizes the very young and the very old. He has conquered no worlds and claims no great achievements, and this is the strength of the film, for it creates a portrait of an average man. Mr. Story has a small house, little money, and few friends, but he does have a sense of personal dignity, pride in his work and, most importantly, a feeling of self worth.

NEVER TOO LATE

Video cassette/Color
58 minutes, 1977
Available from: Pennsylvania State University
Rental : $ 7.00
Purchase: 100.00

The focus is on three main problems of the aged - low income, health care, and isolation - as seen through the eyes of the elderly. It compares these problems as they exist in urban and rural areas and offers ideas on how older individuals can organize to solve some of their problems and improve the quality of life in their local communities.

NOBODY EVER DIED OF OLD AGE

16mm film/Color
65 minutes, 1975
Available from: Films Incorporated and Adult Services, Continuing Education Project
Rental: $ 45.00
Purchase: 650.00

Based on the true-life experiences of Sharon Curtin, author of the best-selling novel of the same name, this film dramatizes the lives of four resourcefully independent citizens in their later years who struggle to survive with some degree of dignity. In episodes ranging from harsh to humorous to poignant, the film depicts many of the problems facing our older adults; also, it combines both praise for independent old people and, at times, outrage at the dehumanization they often experience at the hands of society.

PEEGE

16mm film/Color
28 minutes, 1975
Available from: Phoenix Films and Adult Services, Continuing Education Project
Rental: $ 40.00
Purchase: 395.00

A feeling of worth and knowing someone cares are shown to be important needs at any stage of life. A family visits a dying grandmother in a nursing home. She is blind and has lost some of her mental faculties. The visit is awkward and when the family leaves, the young grandson stays with her for a few lingering minutes. He whispers in her ear, touches her, and is successful in triggering a response. The communication barrier has been broken. When he leaves, she is again alone, but knows someone cares.

THAT THE LAST BE BEST

16mm film/Color & Black and White
60 minutes, 1974
Available from: New York State Office for the Aging
No fee in New York State

This film, produced by the Department of Health, Education and Welfare, focuses on the problems of aging in the United States; it contains a three minute excerpt of the 1971 White House Conference on Aging, which began many of the new programs for older Americans.

IX. DISCUSSION QUESTIONS

1. There are many misconceptions and stereotypes associated with old people and the aging process.

   A) To what extent are such beliefs accurate?

   B) How can these ideas be detrimental to the effective delivery of services to the elderly?

2. In the present system of health care delivery for the elderly there are many strengths and weaknesses.

   A) Is the "medical model" an effective approach to deal with the health care problems of the elderly? Why or why not?

   B) What are some ways that health care can be made more accessible to older persons?

3. There is an increasing trend toward social awareness and activism among many older adults.

   A) Describe some of the organizations that utilize "senior power" in order to influence decision-making regarding the elderly.

   B) Are such groups effective in obtaining favorable results?

   C) As a caseworker, how could you encourage the active participation of older clients in organizations that strive to improve the conditions of the elderly?

4. What are some of the major problems that are associated with housing for the elderly?

   A) Describe the pros and cons of senior citizen high rise apartment complexes. To what extent does this appear to be an adequate solution to the housing problem of the elderly?

   B) List some potential alternatives in housing for older persons. Discuss the strengths and weaknesses of each.

X. INSTRUCTIONAL STRATEGIES

1. Objective: To become aware of the various attitudes that can lead to a negative view of aging.

   Method: Divide into groups of three to five persons. Within each small group setting, participants should list on a sheet of paper several popular attitudes toward aging. Group members should then discuss each of these attitudes, placing special emphasis on whether such attitudes are justified or whether they contribute to a negative view of growing old.

2. Objective: To gain an empathic understanding of some of the basic problems of aging.

   Method:
   1) Invite a panel of older persons to address some of the problems of aging from a subjective perspective. Ask the panel to suggest some of the ways in which they feel that these problems could be resolved.

   2) Have participants play "Life Cycle," a simulation game involving role-playing and peer feedback. This game is available through the Academy of Health Professions (see Appendix D for address).

3. Objective: To become familiar with some of the agencies that attempt to provide services for the elderly.

   Method: Arrange for participants to visit one or more of the following agencies:
   - a senior citizen's center
   - a senior nutrition program site
   - the local Social Security Administration office
   - a senior citizen's housing project
   - a health-related agency that specializes in care for the elderly
   - other relevant agencies

   If possible, divide the participants into smaller groups and have each group visit a different agency. Have each group report to the entire group about their visit.

XI. PRE- AND POST-KNOWLEDGE QUESTIONS

1. T or F Increased industrialization in a society appears to accompany a decrease in the number of old people in that society.

2. T or F The age group 73 and older is currently expanding at a greater pace than any other age group.

3. T or F The median income of old people is about 1/2 to 2/3 less than that of younger households.

4. T or F More than half of the present labor force is under some form of mandatory retirement policy.

5. T or F Social Security was developed as the sole means of support for retirees.

6. T or F Modern technological advances in environmental design have not been adequate in meeting the transportation of the elderly.

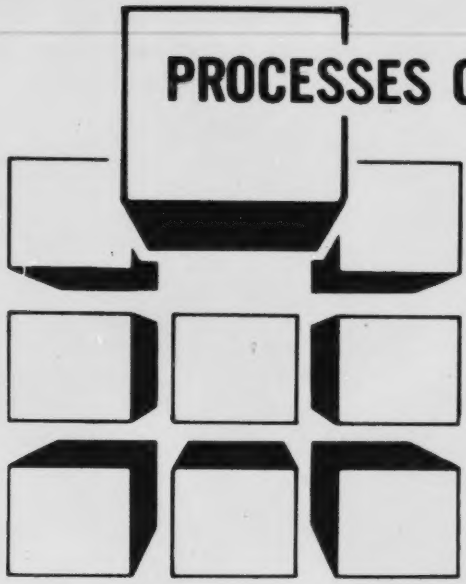
7. T or F Almost half of all elderly New Yorkers own their own homes.

8. T or F The educational and technological advances of the past three decades have helped to minimize the problem of ageism.

PRE- AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. T
3. T
4. F
5. F
6. T
7. T
8. F

PROCESSES OF AGING



I. Training Goal 63

II. Cognitive Objectives 63

III. Affective Objectives 63

IV. Outline 64

V. Sample Lecture 65

VI. Annotated Bibliography 89

  A. Books 89

  B. Periodicals 92

VII. Supplementary Reading Material 94

VIII. Audiovisual Aids 95

IX. Discussion Questions 97

X. Instructional Strategies 98

XI. Pre-and Post-Knowledge Questions/Key 99

I. TRAINING GOAL

To present information that will facilitate a greater understanding of the biological, psychological, and social processes which comprise the aging phenomenon. To show how in spite of physical, sensory, and social decrements, older people have the potential for continued growth and development.

II. COGNITIVE OBJECTIVES

- identify and describe the major age-related changes in biological, psychological, and social functioning
- describe some of the theories that attempt to explain how older people cope with the changes associated with old age
- list five personality types that explain different styles of adjustment to aging
- describe the factors which are important in determining positive life satisfaction

III. AFFECTIVE OBJECTIVES

- develop an awareness of one's own age-related stereotypes and prejudices
- come to terms with one's fears of growing old
- understand the complex forces which shape the older person's experience and circumstances
- develop an empathic understanding of how it feels to simultaneously be subjected to a decline in physical capacities and diminished social status
- understand how the accumulation of role losses in later life can combine to produce a feeling of uselessness in some elderly persons

IV. OUTLINE

A. Introduction

B. Aging as a Developmental Process

C. Biological Processes in Aging

D. Social Processes in Aging

1. Social roles and timing factors
2. Role loss

E. Psychological Processes in Aging

1. Cognitive functioning in later life
2. Personality development in later life

F. Theories of Aging

G. Implications for the Delivery of Services to the Elderly

H. References

V. SAMPLE LECTURE

A. Introduction

Much of the social-psychological theory of human development has been concerned only with the attainment of "maturity," the stage attained in adult years. Professional literature has ignored the older years which were not thought to represent growth years, but rather, a gradual decline peaking at maturity and culminating in death. This concept of aging carried over to the physical sciences as well, so that in medical services, for example, until very recently the treatment of illness in older persons has been one of "making the person comfortable" - treating the symptoms rather than curing the illness. Because, "after all, what good would it do at his age?"

However, we have recently learned that while aging is irreversible, the decline accompanying old age is neither as universal nor as irreversible as was previously believed. We have found that many of the changes associated with old age, except for those caused by illness or accident, actually begin during earlier periods of life and that most of the aging process, instead of being true decline, is really developmental in nature. The aging process itself imposes relatively few major restrictions on functioning.

B. Aging as a Developmental Process

In the developmental view of aging, as losses take place the individual simultaneously and often unconsciously adapts to the change, learning and developing new methods of coping with life situations so that new stages are continually being attained. Aging can be thought of as representing the sum total of changes that occur in an individual from birth throughout the course of life. This developmental progression from birth to old age is actually three simultaneous processes - biological, social, and psychological

Since chronological age is the most common method of reckoning where a person is situated on the life cycle, time in years may be used as a basis for marking off changes which occur during the "average" lifetime. It is important to remember, however, that there really is no one individual who fits the category known as "average," and we must guard against the tendency to overgeneralize about the characteristics of older persons. While certain events traditionally occur at certain designated years, what is perhaps more important is how the individual views these events and the way they affect subsequent actions. Each individual has unique problems and unique talents and skills which may affect the way in which events are viewed. Two examples can quickly be brought to mind. To some, graduation from high school is the signal of adulthood and the beginning of new responsibility. To others, it is merely a way station to college and, perhaps, graduate school. For these individuals, "adulthood" and "responsibility" may not occur until closer to age 30.

The same holds true with retirement. For some individuals, retirement may signal the loss of productive years and may signal encroaching dependency and a subsequent loss of status and esteem. For others, retirement is merely a passage to a whole new life style with very little loss of either psychological or financial independence.

Some of the events on the chronological lifeline might be depicted as follows:

0	Conception
	Birth
6	Begin School
12	Puberty
	Bar Mitzvah - Confirmation
	Driver's License
18	Vote
	Right to Drink Liquor
	Begin Occupation
	Marriage
	Parenthood
30	Begin Energy Decline
40	
50	Death of Parents
	Menopause
	Children Leave Home
	Grand-Parenthood
55	Eyesight Elasticity Diminishes
60	
65	Sensory Acuity Losses
	Retirement
	Death of Spouse
	Income Decline
	Great-Grandparenthood
	Death of Peers
70	Motor Output Deterioration
75	Age Related Health Problems
	Reduced Physical Mobility
	Institutionalization
	Death

It can be seen that some of these events are biological while others are social, but all have psychological implications.

Although it may be said that psychology affects biology - "you are only as old as you feel" - nevertheless, it is biology which ultimately underlies what are perhaps the most crucial events in the life cycle. It is fitting, therefore, to begin with a discussion of the biological process of aging.

C. Biological Processes in Aging

The biological changes which occur in all humans are both physical (e.g., changes in skin and hair texture, changes in the skeletal system) and physiological (e.g., lowered muscle strength and reduced reaction time), but while the physical signs of age are readily apparent, the factors which cause them are not easily understood. Two groups of theories attempt to explain why every living organism withers and eventually dies.

The first set of theories centers around the view that those events leading to eventual death are genetically programmed, that they occur progressively and inexorably with the passage of time, more or less independently of the environment. The second set of theories is concerned with extrinsic or environmental factors, such as disease or injury which contribute to, or accelerate, aging. Most probably, it is a combination of factors, both genetic and environmental, which underlie all aging from birth to old age and death.

Pastalan has described some of these changes which occur in the sensory organs in normal aging. While some authors discuss these changes under psychology of aging, they are described here as physical changes which can be measured. The section on psychology of aging will include a discussion of changes in cognitive functioning as one grows older, as well as a look at some aspects of adult personality.

Mild sensory losses - primarily in the area of vision - begin to occur to adults in full maturity. In about the mid-50s, the lens of the human eye begins to lose its elasticity and gradually starts to become opaque. It is about this time that people who have never before needed eyeglasses begin to require them. At about the same time, hearing acuity begins to diminish. Males, in particular, begin to suffer gradual loss of high frequency sounds. Other noticeable sensory loss, however, does not usually begin to appear until about the mid-70s. At this time, a person begins to experience a reduction in acuity not only of the other sensory organs, but in general health, energy levels, and activities of daily living as well. Between ages 75 and 85, the sensory reduction becomes rather serious. Hearing and vision become real problems. Other sensory functions (smell, taste, tactile sensation) deteriorate as well; health increasingly becomes a problem. With each passing decade beyond age 60, losses occur with increased severity and all these losses which occur tend to diminish the individual's level of independence.

Aging induces other recognizable changes. The skin becomes wrinkled or may develop spots of dark pigment. Hair begins to gray. Eyes may sink further into the skull. The older person's joints, particularly hips and knees, begin to stiffen. Muscles begin to lose strength, although different muscles in the same individual change at differing rates. Hardening of blood vessels may create circulatory problems, making walking difficult. Beyond 75 years, this circulatory problem may even affect blood supply to the brain and thereby reduce the speed of nerve impulses. By age 80, the kidneys are performing only half as well as those of people in their 20s. Finally, with advancing age, the body becomes less efficient at resisting disease.

The losses described above are for the theoretically "average" individual. An important fact to keep in mind is that, in reality, there is considerable variation in empirically noted signs of aging from individual to individual, even of the same age. Whereas the organs of one person may show considerable decline, the same tissue in another individual may show no wear at all. Furthermore, it is also known that even within individuals, one organ may age at a different rate than another. For example, a 70-year old heart may function like one of 60, while the lungs of that same individual may be functioning like those of a 90-year old. Finally, all of these biological manifestations of aging tend to spill over into the psychological and social realms, resulting in changes in the way others view the older person and the way he views himself as well.

D. Social Processes in Aging

Along with the biological changes which occur in any individual, social changes are also occurring from the moment of birth until the moment of death. One of the first consequences of the socialization process is that each individual learns to speak and to communicate his needs and desires to others. At each stage of the life cycle, various other social changes occur which result in greater or lesser interaction with others. Typically, social interaction increases to adulthood. It is during these years that the height of social power and responsibility is reached. Ordinarily these are the years that produce the maximum number and range of social interactions. In the latter years, the number of relationships decreases. As a result of this ebb and flow of social relationships and interactions, the individual (either consciously or unconsciously) continually compensates for the changes as they occur, modifying his own personality and his own behavior, and thus continues the developmental process until his own death.

In the developmental view of aging, while early childhood is regulated primarily by biological factors, adulthood appears to be more closely related to the expectations of society rather than to physical changes or even to social events. These societal expectations are called norms.

1. Social roles and timing factors

Society affects the individual in various age-related ways; not only does the individual learn from others, but he takes on the attitudes of others toward himself. Each individual regulates his own behavior and responds to the behavior of others through a set of norms which prescribe the behavior expected. Through custom, people know what to expect from a policeman, a father, a teacher. Each person plays many roles during the course of a lifetime. During the earliest years, the individual plays the role of someone's child. Later, the individual adds to this the role of student, then perhaps employee, wife and mother all simultaneously. As noted earlier, the middle years produce the greatest number of social interactions. Consequently, the individual plays the greatest number of roles during these years. Most people begin to experience a reduction in roles as they pass middle age.

In addition to prescribing roles, society has decreed the appropriateness of the manner in which each role is played. These are dictated through age norms. Although norms for age-appropriate behavior are not as rigid as they once were, they still exist so that certain styles or certain behaviors seen appropriate for one age group are not seen as appropriate to another.

Neugarten, Moore, and Lowe studied a group of middle-aged, middle-class people in order to discover the degree of consensus regarding age-related characteristics. For the following items, over 2/3 of the respondents were in accord with each time shown.

	age range designated as appropriate or expected
Best age for a man to marry	20-25
Best age for a woman to marry	19-24
When most people should become grandparents	45-50
Best age for most people to finish school and go to work	20-22
When most men should be settled on a career	24-26
When most men hold their top jobs	45-50
When most people should be ready to retire	60-65
A young man	18-22
A middle-aged man	40-50
An old man	65-75
A young woman	18-24
A middle-aged woman	40-50
An old woman	60-75
When a man has the most responsibilities	35-50
When a man accomplishes most	40-50
The prime of life for a man	35-50
When a woman has the most responsibilities	25-40
When a woman accomplishes most	30-45
A good-looking woman	20-35

2. Role loss

Retirement, often thought of as the first big role loss, is, according to Atchley, "the institutionalized separation of individuals from their occupational positions with a continuation of income based on prior years of service. Age is usually the prime consideration in such separation although health may also be a big factor.... Over age 65, about 70% of men and about 90% of women do not have an occupational position." Since our society so highly values productivity, retirement not only signals lowered income, but a loss of status and prestige as well. In addition, removing the individual from the place of employment may mean the removal of a social life as well.

Although retirement may be the first big role loss, there are other losses for which each individual must constantly compensate, such as children leaving home, friends moving away, and so on. With each role loss, either the individual must content himself with fewer social interactions or he must substitute new activities and other roles. These adaptations are discussed in the section on psychological processes of aging.

Loss of spouse precipitates another role among older people. In 1970, more than 50% of the women and 17% of the men over 65 had been widowed. Widowhood produces a huge role loss. Not only is the lifetime companion gone, but very often a set of friendships, dependent upon a relationship with a "couple" disappear. Cumming and Henry reported that women compensated for widowhood by increasing their contact with friends, while men compensated by remarrying. Older women are much more likely to live alone than older men. For those who have based their social life primarily upon their work encounters, widowhood, in addition to retirement, can be an especially lonely experience.

Even more dreaded than widowhood is the role change which accompanies physical and/or financial dependence upon others. The dread of dependency is increased because of societal expectations of people in this position. Children, the poor, or any dependent group, are expected to be grateful for what they receive and, in addition, are expected to give up control of their own lives - not a pleasant prospect for those who have been responsible not only for their own welfare but also for that of others for as long as perhaps 50 to 60 years. Dependency, however, is not as widespread as stereotype would lead us to believe. Atchley points out that about 40% of older people in the U.S. have incomes at or above the modest but adequate level. About 4/5 have independent housing and around half have the use of an automobile. From the data, it appears that older people tend to lose their financial independence first, their independence of movement second, and their independence of household last.

When illness and disability overtake the older individual, while in some instances there are other options, such as moving in with children or hiring full-time nursing assistance, about 4% of the older population are forced to move to homes for the aged or nursing homes. In these institutions, Atchley reports, "opportunities for useful activity, leisure activities, contacts with the outside world, and privacy are all less frequent than they are outside." This is perhaps the most difficult role adjustment of all.

Despite the difficulty, however, and despite the internal biological changes and external social changes taking place - or perhaps because of them - the individual continues to develop, to compensate, and to adjust. These changes are discussed in the section on psychological processes in aging.

E. Psychological Processes in Aging

The study of the psychology of aging focuses, for the most part, on two sets of developmental processes. These processes include cognitive functioning and adult personality. Since both of these sets of factors play an important role in the overall process of adult development, each will be discussed in the present section.

1. Cognitive functioning in later life

The term cognition is a concept which embraces all forms of knowing. Thus, cognitive functioning refers to performance on tasks pertaining to intelligence, learning ability, problem solving, memory, and thinking. For many years, it has been assumed that these capacities tend to decline with increasing age. These assumptions were frequently supported by empirical research. However, it is becoming increasingly apparent that the declines found in earlier studies were often related more to the use of inappropriate research methodologies than to poor performance on the part of the elderly subject. Recent findings tend to show that age-related declines on most cognitive tasks are minimal and, where decline with age does occur, the possibility for compensation also declines. Let's look briefly at some of the evidence.

The misconception that intelligence declines with advancing age is refuted by longitudinal data, where the same subjects are measured at two or more points in time. This methodology demonstrates that the adult level of intelligence is generally maintained into the 50s and 60s, though it begins to show decline in the 70s. An apparent decline in intelligence prior to the eighth decade of life can usually be attributed to disease of the central nervous system or to factors pertaining to the testing situation, such as test anxiety or age-bias in the testing instrument.

Another factor which appears to be related to the measurement of intelligence is the nature of the task which is being performed. For instance, it has been well documented that speed of response declines with age. Thus, on test items which require a rapid response, the older person, who might know the correct answer, is penalized because his response was not quick enough. Some researchers feel that this problem can be minimized by adjusting or eliminating time constraints to compensate for declining physical abilities.

Memory is a process which involves the acquisition, retention, and retrieval of information. Like intelligence, memory has traditionally been assumed to decline with age. However, before considering the effects of age on memory, it is important to differentiate between two types of memory. Short-term recall refers to remembering events that have taken place in the immediate or recent past. Long-term recall involves remembering what has transpired in the more distant past. Evidence based on recent studies shows that while short-term memory tends to decline with advancing age, a decline in long-term memory is not so obvious. Most memory loss, according to current theory, is attributed to a loss of cells and/or neurochemical changes in the central nervous system.

In solving problems, older people are at a disadvantage if many new items of information must be dealt with simultaneously. On the other hand, past experience they have acquired can be very helpful in problem solving. Older people tend toward repetitive behavior. This tendency can be disruptive in situations where the nature of problems requiring solutions is constantly changing. However, this kind of repetition can be advantageous in situations where any change takes place at a slow pace.

Learning ability is widely believed to decrease with advancing age. However, deficiencies in performance may not necessarily be a result of a decline in learning ability, but possibly attributed to a decreasing ability to express what is learned rather than a failure to learn.

In addition to these performance factors, adult learning is influenced by a group of characteristics referred to by Kidd as the "affective domain." Contained within the affective domain are attributes such as motivation, interests, values, and biases. A combination of the characteristics of the affective domain, along with performance factors, have a much greater influence on learning ability than age per se.

Two interrelated theories which attempt to account for lessened learning ability in later life are the "learning set" hypothesis and "rigidity" hypothesis. The learning set hypothesis states that since the older adult has fewer opportunities for learning than the younger person, he tends to get out of the "habit" of learning which has been developed over the years of formal education. Thus, the older person does not know "how to learn" as well as most younger people. The rigidity hypothesis holds that the declining ability to learn new things is due to a tendency toward rigidity, resulting from prior learning. This rigidity causes the individual to cling to information, even though it may no longer be useful in helping him to function within the society. Botwinick, however, based on a review of the literature, notes that "data do not, in fact, show that older adults have been generally more rigid in comparison with young adults, but that this rigidity results at least partly, perhaps totally from cultural and experimental factors, quite independent of age itself." He also suggests that when today's young adults grow old, they may be less rigid than today's older people.

The myths that are associated with the cognitive capacities of the older adult have had a negative effect on the implementation of meaningful educational programs for the elderly. The notion of lifelong learning where, ideally, both formal and informal educational opportunities are made accessible to persons of all ages, though still meeting with much resistance, is now beginning to gain a foothold in our society. The concept of lifelong learning and its relationship to education for the older adult is discussed in greater detail in the module "Community Resources."

2. Personality development in later life

The influence of traditional psychological theory has had a detrimental effect on the view of personality development as a lifelong process. In the classical view of personality, as described by Freud, major personality traits are established in childhood, with any subsequent development which takes place in adulthood simply being an elaboration of the traits which were established earlier. Unfortunately, the popular acceptance of this theoretical viewpoint did little to foster the growth of the psychology of aging.

Perhaps the first major theory of personality to challenge Freud's belief that personality development is complete by adolescence is the view of Erik Erikson. Erikson divides the human life span into eight stages or "ages." Five of these stages deal with psychosocial developmental crises that occur during childhood and adolescence, while the other three crises occur during the adult years. The two developmental crises which occur during middle and old age are: "generativity versus stagnation," where productivity and creativity are seen as the positive outcome, and "ego integrity versus despair," where the positive outcome is an "acceptance of one's one and only life cycle as something that had to be." While Erikson's theory has not received the popular acceptance of some other theories, the viewpoint has had an extremely positive influence on the life span view of personality development.

Perhaps the most important aspect of personality development in later life centers on how well the older person can adapt to the aging process. As individuals grow older, they tend to shift from seeing themselves as people "in charge" of their own lives to seeing themselves primarily responding to the demands of others. Adaptation requires certain skills. Not everyone can successfully grapple with the effects of aging. Some people choose escapism in the form of alcoholism, drug abuse, and even suicide.

A possible explanation for the difficulties which hinder the adaptation process of the older adult is that many of his behaviors come under the scrutiny of two conflicting norms. A good example of this type of situation is that while "sex after sixty" is often viewed as unseemly by many members of our society, the man who fathers a child at age 70 tends to be widely admired. The presence of such dissonant reactions serves to promote confusion among older individuals and, consequently, can hinder a smooth adaptation to the aging process.

Reichard, Livson, and Peterson, based on a study of 87 elderly men, identify five personality types which represent different ways to approach the process of aging. The first category, the mature type, includes those persons who have been able to adapt successfully to the aging process. The second group, the rocking-chair type, face old age with a feeling of passive acceptance. This group is viewed as being relatively well adjusted, though probably not as well adapted as the mature type. The armored type comprises the third pattern of adaptation to aging. This group includes those individuals that ward off their anxieties about growing old by establishing elaborate defense mechanisms such as denial, projection, and fantasy. The fourth category, the angry type, is made up of those persons who are bitter about their advancing age. Here, the bitterness is expressed in the form of anger, which is displayed at specific others or at society in general. Self-haters, the final group, consists of persons who, like the angry type, are resentful about growing old. However, the bitterness which is expressed by self-haters is directed toward the self rather than toward others; this person blames himself for having lived an "incomplete" life.

With regard to these personality types, it is important to remember that one's ability to adapt to advancing age is generally directly related to how one has adjusted to new situations throughout life.

F. Theories of Aging

In order to provide an explanation for individual differences in adaptation to aging and to provide a set of generalized characteristics which comprise "successful aging," several theories have been proposed.

One popular theory of aging is disengagement. According to this view, successful aging is viewed as a mutual withdrawal between the individual and society. There are two types of disengagement: (1) social, where the person gradually reduces his participation in social interactions; and (2) psychological, where the person decreases involvement with interpersonal relationships.

A second explanation is the activity theory, which states that the best way to cope with aging is to maintain the activity level of middle age. Since roles and opportunities diminish with age, this criterion would lead most older people to define themselves as failures.

A third theory of aging is the substitution approach. This viewpoint holds that when people lose certain roles, or the capacity to perform certain activities, they adapt by finding a substitute role. This method of adaptation seems to be more feasible early in life, becoming increasingly more difficult with age as one is faced with a decreasing number of options.

A fourth theory is the subculture of aging theory. According to this view, the elderly comprise a subculture because they tend to have a positive affinity for one another and because elderly persons are excluded, to a greater or lesser extent, from interacting with other groups in the society. The shortcoming of this theory is that it fails to take into account the vast heterogeneity of the older population. Differences in characteristics such as race, culture, and geographical location would probably hinder the development of a subculture of aging.

Finally, the *continuity theory* explains that one's adaptation to the aging process is dependent upon the interrelationships between one's psychological and biological changes and the accumulation of one's experiences throughout life. The strength of this theory lies in the acceptance of a variety of alternate roads for achieving successful aging. However, at the present time, there is very little empirical evidence which either supports or refutes this theory.

Related to the various theories of aging is the notion of *life satisfaction*, where self-perceived happiness and satisfaction with one's present and past life is used as a measure of success in old age. Havighurst, Neugarten, and Tobin isolated five components of life satisfaction. These components are:

1) Zest - liking to do things, being enthusiastic;

2) Resolution and fortitude - not giving up; taking the good with the bad and making the most of it; accepting responsibility for one's own life;

3) Agreement between desired and achieved goals;

4) Positive self-concept - thinking of oneself as a person of worth;

5) Mood tone - showing happiness, optimism, and pleasure with life.

All in all, while none of the theories discussed in this section provide an all-encompassing guide for successful aging, each theory contributes to an overall knowledge of the processes of aging.

G. Implications for the Delivery of Services to the Elderly

A consideration of the basic processes of aging is essential when planning services for the elderly. Only when the caseworker or program planner can become aware of the real needs of the older person is it possible to provide meaningful services.

For example, nutrition services meet the biological, psychological, and social needs of the elderly. Because the incomes of many older people are so low, malnutrition is rampant among this group; yet, nutrition has an important influence on biological aging. With inadequate nutrition, fatigue and lowered resistance to infection may result. The food served at nutrition sites seeks to fill this need. Additionally, the companionship available at such sites serves to reduce social isolation and consequently affects the way the individual views himself. A visit to a meal site at regular times also restores a certain order to the day.

Other services, such as outreach, friendly visiting, and telephone reassurance help to replace lost friends and relatives. Homemaker services can help to ward off the negative feelings associated with dependency. Equally important in this respect is the availability of opportunities on a volunteer or paid basis so that the elderly can continue to contribute to society. Creative activity of this sort has a tremendous therapeutic value.

As has been shown, old age and decline are not synonymous, nor are they universal. Old people must be thought of in the same way we all are - as individuals, each with a unique way of coping. While some may wish to disengage and to withdraw after the death of loved ones, others may wish to make new friends or to remarry. Older people, no more than younger adults, cannot be categorized by stereotypes, and very often people having difficulty in successfully adjusting can be assisted in retaining the autonomy and mental stability of earlier adulthood.

H. References

Atchley, R. C. *The social forces in later life* (2nd ed.). Belmont, Ca.: Wadsworth, 1977.

Botwinick, J. *Cognitive processes in maturity and old age*. New York: Springer, 1967.

Cumming, E., & Henry, W. *Growing old: The process of disengagement*. New York: Basic Books, 1961.

DiCaprio, N. S. *Personality theories. Guides to living*. Philadelphia: Saunders, 1974.

Erikson, E. *Childhood and society* (2nd ed.). New York: Norton, 1963.

Kidd, J. R. *How adults learn*. New York: Association, 1973.

Kimmel, D. C. *Adulthood and aging*. New York: Wiley, 1974.

Neugarten, B. L., Moore, J. W., & Lowe, J. C. Age norms, age constraints, and adult socialization. *American Journal of Sociology*, 1965, *70*(6), 710-717.

Pastalan, L. The simulation of age related sensory losses. *Gerontologist*, 1971, *2*(3, Pt.2), 39-48.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Birchenall, J., & Streight, M. E. *Care of the older adult*. Philadelphia: J. B. Lippincott, 1973.

This book, written primarily for nurses and other direct care personnel, discusses many of the pertinent aspects of the biology of aging and health care of the older adult. The book includes coverage of such topics as the normal aging process, illness in later life, and restorative nursing of patients with various age-related health problems. Since the book is written comprehensibly, it can be quite useful to persons with a non-medical background.

Birren, J. E. *The psychology of aging*. Englewood Cliffs, N.J.: Prentice-Hall, 1964.

The Psychology of Aging is a fundamental textbook on the processes of aging. Included are discussions of social, cultural, biological, and psychological tasks of aging, as well as presentations of the various developmental tasks faced by the older adult. The book also includes chapters concerning employment, maladjustment, and life review and termination. The section entitled "Personality and Aging" includes several studies done on the attitudes and interests of the elderly, as well as a list of criteria for successful aging.

Botwinick, J. *Cognitive processes in maturity and old age*. New York: Springer, 1967.

An essential reference for the topic of intellectual functioning in later life, this book, based for the most part on empirical evidence acquired prior to 1967, includes discussions of intelligence, learning, memory, problem solving, and creativity. Since much of the book includes the description of empirical studies, the book would probably be most beneficial to the reader who has had some exposure to the principles of experimental design. However, the summary chapter should be most appealing to a more heterogeneous audience.

Cumming, E., & Henry, W. E. *Growing old: The process of disengagement*. New York: Basic Books, 1961.

This book is based on findings from the 1955 Kansas City study of adult life, which dealt with the social and psychological aspects of aging. As a result of this study, the authors developed "disengagement theory," where decreased interaction and increased withdrawal from other members of society are seen as normal, healthy patterns of aging.

Eisdorfer, C., & Lawton, M. P. (Eds.). *The psychology of adult development and aging*. Washington, D.C.: American Psychological Association, 1973.

Probably the most comprehensive discussion of the psychology of aging to date, this volume contains articles by many of the leading authorities in the field. In addition to a section on foundations of gerontology, the book contains articles pertaining to experimental, developmental, clinical, and social aspects of adult psychology. As each article provides a thorough review of pertinent literature, the book serves as an excellent reference source.

Kalish, R. A. *Late adulthood: Perspectives on human development*. Monterey, Ca.: Brooks/Cole, 1975.

This succinct but informative text provides an introduction to some of the salient issues of human development during the later years of the human life cycle. The brevity of the book makes it a valuable introduction to the developmental processes associated with aging. The comprehensible manner in which the book is written makes the material accessible to a broad audience. All in all, the book is an excellent starting point for the study of processes of aging.

Kart, C. S., & Manard, B. B. *Aging in America: Readings in social gerontology*. Port Washington, N.Y.: Alfred Publishing, 1976.

This volume consists of a broad collection of readings in social gerontology. Of particular interest to the present module are sections on theories of aging and biological and psychological aspects of aging. The book is an excellent reference when used in conjunction with lecture material and/or a basic text.

Kimmel, D. C. *Adulthood and aging*. New York: Wiley, 1974.

This book approaches the topic of adulthood and aging from an interdisciplinary, developmental perspective. Thus, the focus of the book is on the developmental progression from young adulthood through the remainder of the lifespan in terms of physiological, behavioral, and social processes. It contains discussions of life cycle theories, sex differences through the life cycle, families and singles, personality and psychopathology in adulthood, work and leisure patterns, retirement, and death and dying.

Lumsden, D. B., & Sherron, R. H. (Eds.). *Experimental studies in adult learning and memory*. Washington, D.C.: Hemisphere, 1975.

This book contains 15 empirical studies on adult learning and memory, most of which have been adapted from other publications. Among the contributing authors are: David Arenberg, Carl Eisdorfer, Irene Hulica, Rolf Monge and Sylvia Sherwood. Recommended for students and practitioners in the areas of adult education, gerontology, and psychology, the book will be of greatest value to those readers who have some background in research methodology.

Neugarten, B., & Associates. *Personality in middle and later life*. New York: Atherton Press, 1964.

This book contains a series of studies that attempt to explore personality changes which take place during the second half of the life span. The focus of the book is on a developmental view of adult personality. While half of the studies show evidence of changes in personality past age 40, the other half do not. Special emphasis is placed on the topics of ego functioning, age-sex roles, and personality adjustment.

B. Periodicals

Baltes, P. B., & Schaie, K. W. The myth of the twilight years. Psychology Today, 1974, 7(10), 35-40.

Baltes and Schaie argue that the apparent decline in intelligence with advancing age is "due mainly to generational differences, not to chronological age." Thus, the better performance of younger subjects on intelligence tests is due more to the increasing opportunities for education than to a general age-related decline in performance; it is also due to IQ tests now developed which emphasize the kinds of abilities that are of greatest importance during youth and early adulthood. Thus, such tests tend to discriminate against the older adult. The authors advocate continued research on intelligence in later life based on the rejection of the notion that intellectual decline in later life is inevitable.

Neugarten, B. L. Personality and the aging process. In R. H. Williams, C. Tibbitts, & W. Donahue (Eds.), Processes of aging. New York: Atherton Press, 1963.

This chapter deals with the preliminary findings of the Kansas City Studies, which look at the effect of aging on personality functioning. These findings seem to indicate that between the ages of 45 and 60, the aging process has little effect on the social dimension of personality (social competence) and the life satisfaction dimension of personality (adjustment). However, the author found a significant change with age in some less visible aspects of personality dynamics such as the movement from active to passive mastery of the world, the degree of effectiveness of ego functions, and the amount of energy available to the ego. Of particular importance is the fact that in spite of considerable personality change, people do, in fact, maintain social competence.

Pincus, A. Toward a developmental view of aging for social work. Social Work, 1967, 12, 33-41.

In this article, Pincus discusses the negative influence of the psychoanalytic view of personality development on social work with the elderly. He feels that with such an orientation, social work can only provide opportunities to help the person resist old age and/or accept his plight.

According to the author, a life span view of personality development can help to foster healthy attitudes toward aging, provide some goals which can be set when working with the older client, and increase consideration of the appropriateness of using techniques that have been developed for younger clients with older adults.

Schaie, K. W. Translations in gerontology - from lab to life: Intellectual functioning. American Psychologist, 1974, 29(11), 802-807.

In this article, Schaie cites evidence which supports the view that an age-related decline in performance on tasks involving intellectual abilities is due to a higher level of performance in successive generations rather than to an overall decline on the part of the older person. He points out that a test of intelligence might not be appropriate for old people because it was developed for younger persons, but rather, because the measure was developed for an aged cohort with different "sociocultural exposure."

The final section of the article is an excellent discussion of some of the implications that these new findings might have toward the development of social policy for the elderly. Examples of social policy which might be positively affected by this new perspective of adult intellect are adult education, intergenerational interaction, and present retirement practices.

Wallace, D. M. The biology of aging: 1976, and overview. Journal of the American Geriatrics Society, 1977, 25(2), 104-111.

Wallace summarizes much of what is presently known about the biology of aging. Beginning with a brief discussion of the history of research on the etiology of aging, emphasis then shifts to some of the anatomical, biochemical, physiological, and behavioral changes which take place with advancing age. The author concludes the article with a summary of four prominent theories of biological aging. While the article provides a good overview of the topic, some of the terminology might be difficult for persons without some background in biology.

VII. SUPPLEMENTARY READING MATERIAL

Birren, J. E., Butler, R. N., Greenhouse, S. W., Sokoloff, L., & Yarrow, M. R. (Eds.). *Human aging: A biological and behavioral study*. Publication No.(HSM) 71-9051. Washington, D.C.: U.S. Government Printing Office, 1963.

Birren, J. E., & Schaie, K. W. (Eds.). *Handbook of the psychology of aging*. New York: Van Nostrand Reinhold, 1977.

Cartwright, A., Hockey, L., & Anderson, J. L. *Life before death*. London: Routledge and Kegan Paul, 1973.

Curtin, S. R. *Nobody ever died of old age*. Boston: Little Brown, 1972.

Hendricks, J., & Hendricks, C. D. *Aging in mass society: Myth and realities*. Cambridge, Mass.: Winthrop, 1977.

Jarvik, L. F. Thoughts on the psychobiology of aging. *American Psychologist*, 1975, *30*(5), 576-582.

Neugarten, B. *Middle age and aging*. Chicago: University of Chicago Press, 1968.

Woodruff, D. S., & Birren, J. E. (Eds.). *Aging: Scientific perspectives and social issues*. New York: Van Nostrand, 1975.

VIII. AUDIO-VISUAL AIDS

AGING

16mm film/Color
20 minutes
Available from: McGraw-Hill Films

This film refutes the stereotype that the aged are a homogeneous group. Emphasis is placed on the individuality of old people and some of the life styles that are followed by many elderly persons.

ATTENTION MUST BE PAID

16mm film/Color
27 minutes, 1976
Available from: The Media Guild
Rental : $ 35.00
Purchase: 365.00

This film examines some of the problems that accompany the process of aging. The medical, financial, familial, and emotional problems which can hinder this process are depicted in this thought-provoking film.

DON'T STOP THE MUSIC

16mm film/Color
20 minutes, 1973
Available from: New York State Office for the Aging

Not all older persons choose to disengage from society. This film looks at various programs with which older persons can become involved and examines ways in which communities can help older Americans remain active participants in society.

EVERYBODY RIDES THE CAROUSEL

16mm film/Color
72 minutes (3 parts), 1976
Available from: The University of Michigan
Rental : $ 32.85
Purchase: 350.00 each part
900.00 entire film

Based on Erik Erikson's theory of life span personality development, this animated film provides an interesting look at the various stages of personality development.

The last portion of the film, dealing with personality in adulthood and later life, is most applicable to a discussion of the psychological processes of aging.

OLD MYTHS, NEW REALITIES

Videocassette/Color
58 minutes
Available from: Pennsylvania State University

Rental :	$ 7.00
Purchase:	104.00

Popular attitudes toward aging are explored, along with a discussion of how these attitudes compare with facts about the social, psychological, and biological processes of aging. Comments from nine people, ranging in age from seven to 90, help the viewer to examine how persons of various ages perceive the process of aging.

SEASONS

16mm film/Color
Available from: Connecticut State Department on Aging and
New York State Office for the Aging

Produced for the White House Conference on Aging, this film interjects a touch of humor into more serious questions about the "normal" process of aging and the types of facilities and services that are available to older persons.

SEE NO EVIL

16mm film/Black & White
15 minutes
Available from: Filmakers Library, Inc.

Rental :	$ 30.00
Purchase:	200.00

This film deals with an unmarried couple, both of whom are in their 70s, who live together in a senior citizens' hotel. Bertha is almost blind and very bitter about her loss of independence. Ralph is more accepting of growing old. The film deals quite well with the issue of adjustment to aging.

IX. DISCUSSION QUESTIONS

1. We all have impressions of what old people are like.

    A. How do you picture a typical old person in terms of:

        1. Physical characteristics;

        2. Personality traits;

        3. Social habits;

        4. Interests.

    B. Which of these characteristics do you feel are valid and which invalid?

    C. Can you make any statements regarding generalities?

2. Chronological age is the most reliable means of predicting the changes which occur during the "average" lifetime.

    A. How do you react to this statement?

    B. Why?

3. Society has developed a set of expectations which determine appropriate behaviors for age groups. These expectations are called "age norms."

    A. What are some common age norms in American society?

    B. Do you see any changes occurring in these norms?

    C. How would you evaluate these changes?

4. Gerontologists have discovered several possible avenues for "successful aging."

    A. What factors do you feel are important in determining successful aging?

    B. Why?

5. What can the individual do to prepare himself as much as possible for old age?

X. INSTRUCTIONAL STRATEGIES

1) Objective: To develop a greater understanding of the interrelationship between the various processes of aging.

Method: Invite a panel consisting of a physician, a psychologist, and a social gerontologist to speak about the biological, psychological, and social processes of aging. Have the speakers emphasize how each of these processes is interrelated.

2) Objective: To become aware of the significance of the work role for many older adults.

Method: Ask participants to envision themselves in the role of retiree. Divide participants into small groups (3 or 4 individuals) and have them discuss their feelings and reactions to retirement.

3) Objective: To become familiar with the various personality types of aging persons.

Method: Ask for six volunteers. Five of these volunteers will assume the roles of older persons who fall into one of the five personality types discussed in the sample lecture. The other volunteer will serve as an interviewer. Each "personality type" is interviewed for five minutes. The exercise concludes with a group discussion about the extent to which each of these personality types appears to have adjusted to the aging process.

XI. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F Chronological age is the most effective measure of age-related capacities.

2. T or F Sensory loss is a part of the normal aging process.

3. T or F More than one-half of women age 65 or older are widowed.

4. T or F About 11% of the older population lives in nursing homes or homes for the aged.

5. T or F Intelligence tends to decline with increasing age.

6. T or F The theory of personality proposed by Erik Erikson states that major personality traits are established in childhood and that all subsequent development is simply an elaboration of these traits.

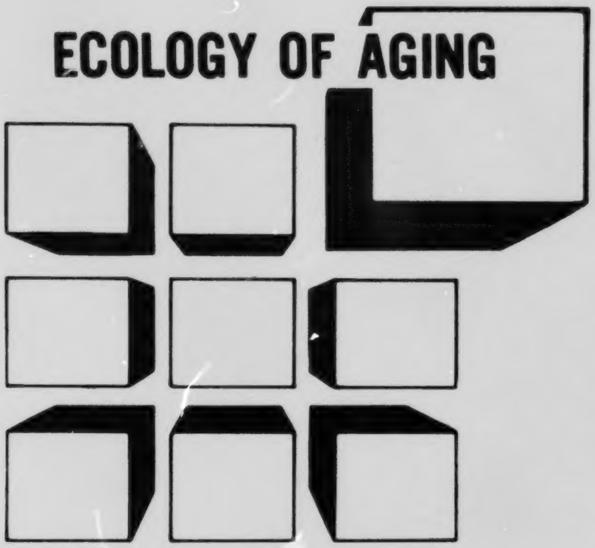
7. T or F In disengagement theory, successful aging is viewed as a mutual withdrawal between the individual and society.

8. T or F Short-term memory tends to decline with age.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. T
3. T
4. F
5. F
6. F
7. T
8. T

ECOLOGY OF AGING



I. Training Goal 103

II. Cognitive Objectives 103

III. Affective Objectives 103

IV. Outline 104

V. Sample Lecture 105

VI. Annotated Bibliography 118

- A. Books 118
- B. Periodicals 118

VII. Supplementary Reading Material 123

VIII. Audiovisual Aids 124

IX. Discussion Questions 126

X. Instructional Strategies 127

XI. Pre-and Post-Knowledge Questions/Key 129

I. TRAINING GOAL

To present information that will increase understanding of the components which make up one's physical and social environment. To show how these components can affect the quality of life of the older person.

II. COGNITIVE OBJECTIVES

- describe some of the elements which affect the environment of the elderly

- list the most common types of living environments where the elderly can be housed

- describe several ways in which the environment can be modified to better meet the needs of the elderly

- identify some of the sensory losses which serve to reduce the older person's life space

III. AFFECTIVE OBJECTIVES

- develop a feeling for what it might be like to exist in a very limited life space after years of virtually unlimited life space

- modify any of one's own attitudes which might serve to create dependence in older people

- understand what it might feel like to live in an institutional setting where there is little opportunity to be alone

- overcome fears of coming into physical contact with an older person

IV. OUTLINE

A. Introduction

B. The Environment of the Elderly

1. Life space
2. Sensory losses accompanying advancing age
3. Autonomy
4. Privacy

C. Living Environments

D. Helping the Older Person to Deal with Ecological Aspects of Aging

1. Modifying the environment
2. The need for continued contact

E. References

V. SAMPLE LECTURE

A. Introduction

Ecology can be defined as the study of natural systems, where special emphasis is placed on the interdependence of each element in the system. Thus, the ecology of aging is the study of how older people function within their social, psychological, and physical environments. The present discussion will examine some of the elements which comprise the environment of the elderly. Emphasis will then be shifted to a look at some of the types of living arrangements that are available to the older person. Finally, the discussion will focus on some of the ways in which the environment can be modified in order to make it more accessible to the older person.

B. The Environment of the Elderly

With increasing age, individuals begin to experience sensory losses as well as a decline in psychomotor capacities. At the same time, because of a reduced mobility and fewer opportunities for interpersonal interaction, there is an increasing tendency toward isolation. The combination of these factors serves to greatly diminish the scope of one's environment. Some of the elements which are pertinent to this increasingly diminishing environment are life space; sensory loss; the need for autonomy, privacy, and adaptation.

1. Life space

Life space has been defined as the extent of the world which a person accepts as bearing on his or her conduct. Life space is a combination of one's physical and social environments with his or her previous learning experiences. In general, however, life space is highly related to age. The world of the child is very tightly constricted. The extent of the newborn baby's life space is his own body. As he grows and becomes more mobile, his crib is the boundary. Soon, he can crawl, but his physical range is only what adults will allow.

During early adulthood, a person probably reaches his maximum life space. The individual's degree of involvement with the world at large becomes great and both time and distance take on a new meaning. Physically, the adult has the range (if he has adequate financial resources) of the entire world for employment and enjoyment. Life space, however, is dependent upon more than just the financial resources of each individual. Different persons vary in the size of their life space, depending on such factors as their social position, education, and even their own personality disposition. Unlike the child, the mature adult has the opportunity to plan his own time. The adult can decide the degree to which he is willing to plan ahead, which is another way of extending life space, and also how to parcel out each moment. It is up to him to decide how and with whom he chooses to spend his time.

Gradually, beginning in late middle age, life space tends to constrict. Plagued with problems, such as declining health and diminished income, most older people tend to become more limited from a geographic standpoint. They become increasingly neighborhood based. Often, they become neighborhood bound. Physiological changes which limit the person's ability tend to diminish physical life space. For those who develop severe impairments, it is possible that confines may not extend beyond a room or even a bed.

Unlike the child, however, who has never known a larger life space, the adult has a lifetime of accumulated experience. He has patterns of reaction and behavior. Such persons many long for lost confidantes or intimacies. The need to occupy a larger psychological and social life space continues to exist despite the narrowed physical life space. Confinement to home or an institution should not preclude news of the outside world nor contact with friends and family.

2. Sensory losses accompanying advancing age

Sensory loss is a normal part of the aging process. Even those older persons who are in good health will have experienced some sensory losses, such as lessened hearing ability or diminished eyesight. The senses of smell, taste, and touch also decline with age. Since people can only respond to their environment in terms of their senses, the world of the very old person is literally a different one from that of younger people.

Pastalan and Carson's theory of environment as language suggests that environment consists of a system of cues that tell us how to respond to particular situations. However, the environment communicates meaningfully only to the degree that the cues which are sent out can be received and perceived by an individual. If a person fails to perceive a certain stimulus, a stop sign, for example, he cannot respond to it. Pastalan and his associates have been able, with the aid of physical devices, to simulate and mimic the deterioration of stimulus cues due to sensory diminution. Through the use of this empathic mode, students are able to experience the same sensations as the elderly adult.

Tactile loss results in a lowered ability to judge temperature and, perhaps even worse in the eyes of the older adult, it causes difficulty in performing simple tasks like turning pages. Even unfolding napkins can become a chore.

Visual loss results in light scatter or glare. Older individuals experience difficulties in depth perception. Thus, a flight of steps, or even stepping up or down a curb, presents a problem.

Auditory losses often make it difficult for the older individual to separate conversation from background noise. Very often there is a loss of ability in determining the direction from which a sound is coming.

Sense of smell declines with increasing age. This olfactory loss is greatly associated with a decline in the ability to taste. When the ability to discriminate subtle flavors diminishes, the individual may lose the desire to eat. Eating becomes merely a way to sustain life rather than a way to increase pleasure. Often, the failure to eat properly results in nutritional deficiency.

3. Autonomy

A second factor, one which has great bearing on the quality of life, is autonomy. Automony is synonymous with independence. An autonomous individual is in control of his or her own life. Elderly people who have the opportunity to determine for themselves the scope of their activities and interaction are much more content than those older persons who have less control over their lives.

The concept of autonomy suggests that time is spent in whatever way is deemed meaningful by the individual. A frequent problem in planning services or activities for the elderly is a failure to determine whether or not potential participants actually want to participate in the service or activity.

Older people, depending upon their past life experiences, have many different opinions on how time should be spent. Some believe that old age and retirement have freed them from the necessity of "doing things." Others believe that "idle hands are the devil's workshop." Arts and crafts and leisure time have not been a part of the lifestyle of the majority of today's older persons. Such activities cannot fill the life of a person who does not enjoy participating or, in fact, resents forced involvement. In allowing the person the opportunity to make his or her own decisions as to how time should be spent, we acknowledge that individual as a person. It is, in fact, an encroachment upon the older individual's life space to demand that an older person participate in leisure time activities (even as part of "therapy") in which he has no interest or desire. On the other hand, ways should be found for those who wish to remain physically and mentally active to participate in activities which are meaningful to them. The right of the individual to decide the degree of his participation is equally important whether the individual resides in the community or in an institution.

4. Privacy

In addition to the wish to maintain control over the use of time, older persons have a need to control their space and social network. This means that beyond wanting to determine where to live and under what conditions, each person needs to balance the need for friendships and relations with others against personal needs for privacy.

Privacy, as it is used here, is defined as the right of the individual to decide what information about herself should be communicated to others and under what conditions this communication should take place. Every person needs moments "off stage," when there is no need to face the world. It is only in total institutions, such as prisons or hospitals, that society has come to expect a total lack of privacy that includes monitoring of bodily functions. The two fears most often expressed when people are asked if they would consider living in a home for the elderly are lack of autonomy and regimentation ("You have to do everything on time - just like in the army") and lack of privacy ("Everyone always knows everyone else's business").

Each individual has a need to protect both physical and mental privacy. The person who is able to withdraw physically can protect both the privacy of his bodily functions and what he chooses or not chooses to communicate to the world. For those who are unable to withdraw, the ability to monitor one's own use of time is one way of protecting mental privacy.

All in all, it can be seen that each of the elements of the environment discussed above can have an effect, either positive or negative, on how the older individual interacts within his or her surroundings.

C. Living Environments

In addition to the social and psychological aspects of the environment, there is another dimension to the ecology of aging. The one which is perhaps most apparent is the physical aspect of the environment, specifically one's immediate living arrangement. The type and quality of an individual's living environment is dependent on a variety of factors, such as financial resources, health, family situation, and minority status. Other relevant considerations are related to whether the person owns or rents his residence and whether he resides in an urban or rural setting.

One of the most predominant myths associated with aging is that most older people are institutionalized. In actuality, only 5-7% reside in institutions. Seventy percent of all persons over age 65 own and reside in their own homes. Most of these homes are located in inner city areas or small rural towns. Only about 4% of all older persons live in old age institutions. However, a much larger proportion of people over 65, estimated as high as 25%, die in an institution. Thus, it can be seen that a significant number of older people will, at one time or another, spend some time in a home for the aged.

Most older people live in one of three types of settings: single-family homes; apartments; and health-related institutions, such as a skilled nursing facility. As was pointed out earlier, older people tend to prefer the type of living arrangement that will afford them the greatest degree of independence. Research has found that elderly individuals usually express a desire to live alone or with a spouse in one's own home. However, people who move into specialized housing projects also appear to be quite happy with their arrangement.

D. Helping the Older Person to Deal with the Ecological Aspects of Aging

In spite of diminished life space and declining sensory capacities, it is possible for many older persons to maintain a rather high level of interaction with their environment. Two ways to help the older person maintain this interaction are modification of the environment in order to compensate for age-related losses and minimization of the isolation that is so prevalent among many older persons. Each of the factors warrant further examination.

1. Modifying the Environment: Ways to Better Meet the Needs of the Older Person

It is possible to alter the environment to make it more accessible to the older adult. Barrier-free design can make it easier for a person with diminished physical capacities to better negotiate the immediate physical environment. At the same time, the social environment of the older individual, which is quite frequently characterized by isolation and loneliness, can be modified through being able to keep in touch with significant others. Let's look for a moment at each of these factors.

It is important for caseworkers to be sensitive to sensory losses that occur as part of the normal aging process. Very often, the uninitiated will attribute the lowered ability of the elderly to respond to stimulus cues to inattentiveness or confusion. Various studies, such as the work of Pastalan and Carson, have identified many means by which environments can be modified to satisfy the needs of the elderly for safety, security, belongingness, and self-esteem. Barriers to access of most buildings can be removed by the installation of ramps and handrails. Sensory losses can be compensated for by redundant cueing and higher levels of stimulation. An example of these compensatory measures would be an electric switch which utilizes both color coding and raised lettering. The switch can thus be seen as well as felt. Such a switch could even be equipped with a buzzer for aural stimulation. Hot and cold water faucets could be similarly equipped. Showers and bathtubs could be equipped with handrails and slip-proof treads. Stairways can have treads painted in alternate colors so that one step can be distinguished from another.

On a larger scale, transportation systems can be modified to better accommodate the older person who has experienced a decline in psychomotor capacities. Automobiles can be designed with an instrument panel which is easy to read. Subway and bus doors and steps can be designed to facilitate easy entry and departure. Traffic light timing can be reset in a way which allows the older pedestrian to cross the street in an ample amount of time.

2. The Need for Continued Contact

Two major types of needs are fulfilled through providing the older person with continued opportunities for contact with others. First, there is the emotional need, where the contact is in the form of interpersonal interaction. Second, there is the physical need, where the need is fulfilled through physical contact with the older person, such as touching.

As was discussed earlier, most people experience a need for privacy. At the same time, however, there is a need for the continuity of interpersonal relationships. Despite advanced age, most persons benefit from close friendships and conversation with a confidante. The role of the caseworker can be highly valuable here. By being a good listener, the caseworker can help to facilitate such social interaction. By recognizing the necessary balance between social interaction and the need for privacy, the caseworker can help to keep even the less healthy older person participating in life.

Some persons, men and women alike, manifest their need for closeness by physical contact. Unable to be physically near to those whom they have loved or who have loved them, they still have a need to touch and to be touched. Touching is a demonstration of communication and responsiveness to and with another human being. It is important for caseworkers who work with the elderly to examine their own attitudes and to divest themselves of the "dirty old man" concept. If the unexpected touch by an old person is bothersome to the caseworker, it can be controlled. The caseworker can control the touching and still meet the need. In working with clients who exhibit a need for personal contact, the caseworker can shake hands or touch a shoulder at the beginning and/or conclusion of each meeting. Allowing the client to place his hand on yours enables you to see the touch coming. An effort should be made by the caseworker to reduce the physical isolation of the older person. It should be obvious that physical isolation only serves to accentuate the overall loneliness which is experienced by so many older people.

In summary, it can be seen that it is possible to modify the environment in a manner which will provide opportunities for the older person to engage in both emotional and physical contact with other persons. Hopefully, this modification can help to slow the pace at which the life space of the elderly person diminishes and can help to forestall the onset of increased dependency.

E. References

Atchley, R.C. The social forces in later life (2nd Ed.). Belmont, Ca.: Wadsworth, 1977.

Back, K.W., & Gergen, K.J. Cognitive motivational factors in aging and disengagement. In I.H. Simpson & J.C. McKinney (Eds.), Social aspects of aging. Durham, N.C.: Duke University Press, 1966.

Gelwicks, L.E. The older person's relation with the environment: The influence of transportation. In E.J. Cantilli & J.L. Shmelzer (Eds.), Transportation and aging: Selected issues. (Proceeding of the interdisciplinary workshop on transportation and aging, Washington, D.C. May 24-26, 1970). Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1974.

Kahana, E. The humane treatment of old people in institutions. Gerontologist, 1973, 13(3), 282-289.

Pastalan, L.A., & Carson, D.H. Spatial behavior of older people. Ann Arbor: The University of Michigan, 1970.

Steinfield, E.H. Ecology of aging. In D.L. Slover, et. al. (Eds.). An instructor's handbook for the development of a basic course in gerontology. Syracuse, New York: Syracuse University All-University Gerontology Center, 1975.

V. ANNOTATED BIBLIOGRAPHY

A. Books

Hickey, T., & Fatula, B. *Sensory deprivation and the elderly*. University Park: The Pennsylvania State University, 1975.

This manual, produced by the Gerontology Center at Pennsylvania State University, is a part of a series of lessons in gerontology. The primary objective of the manual is to improve social interactions between service providers and the elderly. The reader is encouraged to develop insight into problems caused by sensory deprivation and by negative social attitudes toward the aged.

Pastalan, L.A., & Carson, D.H. (Eds.). *Spatial behavior of older people*. Ann Arbor: The University of Michigan - Wayne State University, 1970.

This book contains a series of articles on the ecology of the aging by a number of authorities in the field. Topics covered include use of space by an aging population, levels of adaptation to changed surroundings, and an overview of spatial behavior.

B. Periodicals

Cantor, M.H. Life space and the urban elderly. *Gerontologist*, 1975, *15*(1), 23-27.

This description of a study of urban elderly residents of the inner city explores the extent to which elderly people possess a functioning social support system; for example, assistance between generations, intimates, neighbors, and children. It also examines the strengths and weaknesses of city life as perceived by the elderly.

Carp, F.M. The mobility of retired people. In R.A. Kalish (Ed.), *The later years: Social applications of gerontology*. Monterey, Ca.: Brooks/Cole Publishers, 1977.

This research article reports the kinds of transportation older people used in San Antonio, Texas.

In delineating the results of the study, the author outlines the transportation requirements of all older people.

Costa, F.J., & Sweet, M. Barrier-free environments for older Americans. Gerontologist, 1976, 16(5), 404-409.

This article enumerates the advantages of housing designed to improve the living conditions of mobility-restricted or otherwise handicapped older persons. Architectural methodology is discussed, along with such elements as current legislative provisions and cost factors in building design. The article concludes with the social ramifications of such architectural designs for the society.

Gelwicks, L.E. The older person's relation with the environment: The influence of transportation. In E.J. Cantilli, & J.L. Shmelzer (Eds.), Transportation and aging: Selected issues. (Proceedings of the interdisciplinary workshop on transportation and aging, Washington, D.C., May 24-26, 1970). Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1974.

This article explores life space as related to the biological, social and psychological age of the individual, emphasizing the role transportation design plays in improving the quality of the older person's life space.

Lawton, M.P. Supportive services in the context of the housing environment. Gerontologist, 1969, 9(1), 15-19.

This article investigates the older person's orientation toward supportive services. The impact of these services upon behavior is considered, including the relationship between the provision of services and increasing dependency.

Lawton, M.P. Planner's notebook: Planning environments for older people. Journal of American Institute of Planners, 1970, 36(2), 124-129.

This article, analyzed within the concept of the "prosthetic" environment, deals with the environmental and behavioral transactions of older people. The prosthetic approach attempts to provide environmental supports to maintain optimal functioning for those with fixed levels of disability. Examined are a number of plans directed toward these prosthetic disabilities: life-maintenance, perception, cognition, self-maintenance, social behaviors, and self-concept.

Lawton, M.P. Social ecology and the health of older people. American Journal of Public Health, 1974, 64, 257-260.

The author discusses how the environment in which the elderly person is living may be the cause of some of the apparent "effects of aging." He describes how elderly people have to cope with environments designed for younger people and hypothesizes that aging increases the importance of environmental influences. "The less competent the individual in terms of personal disability or deprived status, the more susceptible is his behavior to the immediate environmental situations."

Lawton, M.P., & Byerts, T.O. Planning physical space. In R.A. Kalish (Ed.), The later years: Social applications of gerontology. Monterey, Ca.: Brooks/Cole Publishing Co., 1977.

This article discusses several considerations that emerge in planning for housing the elderly, emphasizing the role of policy. The necessity for policy, together with planning, is the keystone of the article and of social improvement.

Lawton, M.P., & Kleban, M.H. The aged residents of the inner city. Gerontologist, 1971, 11(4)1, 277-283.

This article examines a group of elderly Jews living in what was once a fashionable and prosperous area of Philadelphia and which has now become a high-crime, low-income urban ghetto. Emphasis is placed on examining the effect of environmental factors upon the apparent deprivations of this group in health and life-satisfaction.

Pastalan, L.A. The simulation of age-related sensory losses: A new approach to the study of environmental barriers. Gerontologist, 1971, 2(3)2, 39-48.

This study reports a simulation model which duplicates relevant environmental experiences of an elderly population suffering from sensory deficits. The four senses - auditory, visual, olfactory and tactile - are simulated for purpose of creating empathy with the older person having sensory loss. The article concludes with suggestions for the improvement of the environment.

Sherman, S.R. Mutual assistance and support in retirement housing. Journal of Gerontology, 1975, 30(4), 479-483.

This study regarding mutual assistance networks compares reports by 600 residents of six facilities for the well-elderly with those of a control group of people living in a dispersed housing in the community. Retirement housing residents generally did not suffer from a relative lack of assistance from children nor benefit overall from greater assistance from neighbors.

Shore, H. Designing a training program for understanding sensory losses in aging. Gerontologist, 1976, 16(2), 157-165.

This article discusses developments in research and teaching concerning age-related sensory losses, Techniques related to visual, auditory, tactile, olfactory, and kinesthetic losses are included. Some existing resources available to institutional programs for the elderly are described.

Storandt, M., & Wittels, I. Maintenance of function in relocation of community dwelling older adults. Journal of Gerontology, 1975, 30(5), 608-612.

This research study compared relatively healthy older people who moved voluntarily with nonmovers. The results indicate that the noninstitutionalized elderly who choose to relocate face no risk comparable to that experienced by the institutionalized population who experience relocation.

Williams, R.H. Changing status, roles, and relationships. In C. Tibbitts (Ed.), Handbook of social gerontology: Societal aspects of aging. Chicago: The University of Chicago Press, 1960.

This chapter examines the importance of theory in the study of aging, specifically the theory of action as developed by Talcott Parson. Social life space is examined as a matrix of social relationships, and the role of personality theories in the changing relationships of older people is discussed.

VII. SUPPLEMENTARY READING MATERIAL

Barrows, C.H., Jr. Ecology of aging and the aging process-biological paramenters. Gerontologist, 1968, 8(2), 84-87.

Friedman, E. Spatial proximity and social interaction in a home for the aged. Journal of Gerontology, 1966, 21, 566-570.

Lawton, M.P., & Simon, B. The ecology of social relationships in housing for the elderly. Gerontologist, 1968, 8, 108-115.

Lawton, M.P., & Nahemow, L. Ecology and the aging process. In C. Eisdorfer, & M.P. Lawton (Eds.). The psychology of adult development and aging. Washington, D.C.: American Psychological Association, 1973.

Little, K.B. Personal space. Journal of Experimental Social Psychology, 1965, 1, 237-247.

Solomon, P., et. al. Sensory deprivation: A symposium held at the Harvard Medical School. Cambridge: Harvard University Press, 1965.

Weiss, A.D. The role and importance of sensory functions in aging. Proceedings of Seminars 1961-1965. Chapel Hill: Duke University Press, 1965.

VIII. AUDIOVISUAL AIDS

THE INNER WORLD OF APHASIA

16 mm film/Color
24 minutes, 1968
Available from: North Texas State University

The emotional world of two aphasics (people with loss of power to use and understand speech) is dramatically presented on film. This film is useful for professionals in social work, speech pathology and occupational therapy to gain understanding of how to work with patients (clients) who cannot communicate verbally.

MAKE A WISH

16 mm film/Color
5 minutes, 1976
Available from: Pennsylvania State University
Rental: $ 5.50
Purchase: 40.00

This film is a useful tool in stimulating discussion of the physical, social, and psychological problems resulting from sensory deprivation. The film depicts a family birthday party for the grandmother, who is 75, and the granddaughter, who is five. Audio and visual simulation techniques enable viewers to experience restricted sensory feedback as received by an elderly person with sight and hearing loss, as well as that received by a younger person with normal sensory capacities.

PERSPECTIVES ON AGING: PHYSICAL CHANGES AND THEIR IMPLICATIONS

Filmstrip series (series 2)
18 minutes, 1976
Available from: Concept Media
Purchase: $70.00

This 18 minute filmstrip, one part of a five-part series on aging, examines the physical changes that accompany aging and the manner in which the body systems and functions are affected by them.

AGE RELATED SENSORY LOSSES - AN EMPATHIC APPROACH

3/4" and 1/2" videotape/Color
28 minutes, 1974
Available from: University of Michigan

This videotape program, produced by Leon Pastalan, depicts an elderly woman's adaptation to her sensory losses: sight, smell and hearing. The tape focuses on the interaction between her and her family at the dinner table, and clearly depicts the effect sensory loss has on interaction and understanding. The videotape is an excellent sensitizer for caseworkers dealing with elderly clients.

SENSORY DEPRIVATION AND THE ELDERLY

Videocassette/Color
2 hours, 1974
Available from: The Pennsylvania State University
Rental: $ 9.00
Purchase: 140.00

This program is comprised of two one-hour color videocassettes. They present a complete program on sensory deprivation and the elderly and are based on the Pennsylvania State University Manual described in the book section of this listing. Topics in this presentation include changes in sensory modalities, environmental adaption, territoriality, and proxemics.

IX. DISCUSSION QUESTIONS

1. Each type of housing arrangement has good and poor aspects.

   A) Discuss the strengths and weaknesses of the most frequent living environments of the older person.

   B) Which environment would you prefer? Why?

2. It is often said that the elderly must be dependent upon others.

   A) What kinds of factors lead to this diminished autonomy in many older individuals?

   B) How many of these factors are legitimate concerns of the elderly and how many are actually little more than myths which have been contrived to place the elderly in a dependent role?

3. Privacy is an important element in the lives of nearly all people.

   A) Discuss the opportunities for privacy that exist for elderly persons in each type of living environment.

   B) Which environments provide "too little" opportunity for privacy?

   C) Which ones provide "too much" opportunity for privacy?

   D) How can too much or too little privacy be detrimental for the older adult?

4. Is it feasible to think in terms of emphasizing a residential model when it appears that there is more money available for reimbursement for nursing home care than for other types of supportive services?

X. INSTRUCTIONAL STRATEGIES

1. Objective: To develop a greater understanding of life in a senior citizen housing setting.

   Method: Visit a senior housing building. After the visit, discuss the advantages and disadvantages of this type of housing arrangement. Place special emphasis on factors such as proximity of the building to public transportation, shopping areas, recreation sites, and other community facilities. Also, discuss the extent to which residents of the building appear to be segregated or integrated into the mainstream of society.

2. Objective: To develop an empathic awareness of the ways in which sensory deprivation can affect the environment of the elderly individual.

   Method: Involve participants in a variety of exercises that simulate various types of sensory motor loss. Examples of simulations include:

   Arthritis/Stiff Joints

   - Put on a pair of gloves and try to button your shirt or blouse.
   - Wrap elastic bandages around your knees and try to walk or climb stairs. Then, wrap the bandages around your elbows and try to put on a coat or other clothing.

   Stroke or Paralysis

   - Try writing your name and address on a sheet of paper, using your opposite hand. Would this be acceptable on legal documents?
   - Secure a yardstick around the outside of your leg so that movement of the knee is restricted. Walk around the room and climb some steps.

   Hearing Loss

   - Place earplugs or cotton balls and earmuffs in each ear. Carry on a conversation with someone.

Visual Problems

- Wrap a pair of swim goggles or glasses with cellophane wrap. Read a newspaper or walk around a room.

Speech Impediment

- Place a clean ping-pong ball in your mouth. Try carrying on a conversation.

3. Objective: To give a feeling of what it is like to grow old and what it is like to try to help people who are growing old.

Method: Administer the "End of the Line" simulation game. The complete game kit with materials is available from Urbex Affiliates, Inc. (P. O. Box 2198, Ann Arbor, Michigan 48106). The manual only is available from the Adult Services Project.

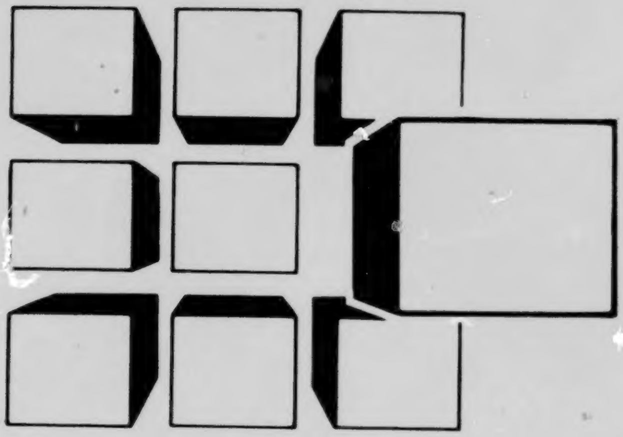
XI. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F Life space is solely the combination of one's own psychological and social environment.
2. T or F Early adulthood is the period when a person probably reaches his maximum life space.
3. T or F Olfactory loss is not associated with taste.
4. T or F The inability of the elderly to respond to stimulus cues is often interpreted as inattentiveness or confusion.
5. T or F Redundant cueing is one means of compensating for sensory loss.
6. T or F Older persons seldom have a need to control space and the social network.
7. T or F Most people over 65 own their own homes.
8. T or F It is estimated that up to 25% of people over 65 die in an institution.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. T
3. F
4. T
5. T
6. F
7. T
8. T

WORKING WITH THE AGED CLIENT



I. Training Goal 133

II. Cognitive Objectives 133

III. Affective Objectives 133

IV. Outline 134

V. Sample Lecture 135

VI. Annotated Bibliography 154

A. Books 154

B. Periodicals 155

VII. Audiovisual Aids 158

VIII. Discussion Questions 160

IX. Instructional Strategies 161

X. Pre-and Post-Knowledge Questions/Key 163

Appendix 1: Sample Cases 165

I. TRAINING GOAL

To recognize some of the types of skills which can be developed to enhance work with the older client. To become sensitive to the individual needs of the older client.

II. COGNITIVE OBJECTIVES

- differentiate between the kinds of loss commonly experienced by the elderly

- identify several factors that are important in establishing rapport with the client

- list some of the methods the caseworker can utilize in making a comprehensive client assessment

- develop skills in investigating and interpreting relevant cultural, historical, and environmental influences on the client's behavior

III. AFFECTIVE OBJECTIVES

- become sensitized to the need to view each elderly client as an individual

- develop a self-awareness of one's motivation for working with an older clientele

- understand one's fears, anxieties, and stereotypes associated with working with the elderly

- develop an appreciation of the importance of reminiscence as a form of life review

- become aware of the various ways the elderly client can perceive the role of the caseworker, and be sensitive to the impact of these perceptions on the worker-client relationship

IV. OUTLINE

A. Introduction

B. Identifying the Aged Client; Chronological Versus Functional Age

C. Identifying the Caseworker

D. Understanding Loss

E. Problems of Entering the Casework Relationship

F. Casework with Older Clients

1. The agency
2. The caseworker

G. Evaluation of the Aged Client

H. The Importance of Reminiscing

I. The Worker-Client Relationship

J. References

V. SAMPLE LECTURE

A. Introduction

Robert Butler, the Director of the National Institute of Aging, has said, "Students who are otherwise humane and interested in people are likely to be uninterested, repulsed, or frightened by the thought of working with the elderly. Educators, professionals, and lay people alike react in a similar manner." This phenomenon of antipathy toward the elderly has been attributed to a national prejudice called ageism. Ageism is the systematic stereotyping and discrimination against old people similar to the prejudices regarding race (racism) and gender (sexism). Ageism affects young and old people alike. Some young people view older people as being useless members of society. Many old people, having been similarly socialized, accept these attitudes and thereby often settle for second-class treatment.

Caseworkers with an elderly clientele need to recognize that old age is not something "different," but rather that old age can be viewed as a developmental stage of an ongoing life process. Thus, in the same way that special skills are developed for working with children or adolescents, special skills can be developed by the caseworker to enhance working with the aged client.

B. Identifying the Aged Client: Chronological Versus Functional Age

There are persons in their advanced years who are regarded as young in terms of health, appearance, and/or attitude. Similarly, there are persons in their middle years who somehow have always seemed to be "old." What, then, constitutes being old?

Usually, when a person is asked his age, the response will be the number of years that he has lived. This figure is referred to as one's chronological age. Traditionally, chronological age has been the almost exclusive determinant of who is "old."

In recent years, however, there has been a trend toward determining age on the basis of how well the individual is able to function and to interact within his day-to-day existence. This is the concept of functional age. Functional age would appear to be an important concept, since each person ages at a different rate, and these rates do not necessarily coincide with chronological age.

Bell describes six components which comprise a person's functional age: biochemical, auditory, anthropometric, ability, personality, and social. Biochemical age is determined by biological analyses of blood serum and urine. Auditory age is specified by a clinical assessment of a person's auditory functioning.

Anthropometric age refers to the physical changes which take place with advancing age. Examples of these outward alterations include graying of hair; loss of hair and teeth; elongation of ears and nose; wrinkling of skin; diminished eyesight and hearing; and postical changes.

Ability age is determined by how well a person can perform verbal, perceptual, and motor tasks. Personality age consists of a multifactor description of a person's patterns of behavior, values, and attitudes. Ability age and personality age might be combined in order to determine an individual's psychological age.

Finally, social age consists of a set of sociological assessments of life style which pertain to family, work, and retirement situations. Sociologically, a person is old when society defines him as such. Age 65 is usually the demarcation between middle and old age. This arbitrary age was "borrowed" from the social legislation of the 1880's of Chancellor Otto von Bismark of Germany, who determined 65 to be the "proper" age for retirement.

Thus, it can be seen that in identifying the older client, such factors as biological, psychological and sociological factors (functional age) must be given equal consideration with chronological age in making an assessment of how well that individual will be able to function within and to maintain control over his environment.

C. Identifying the Caseworker

Many caseworkers work with the aged because they have a genuine interest and concern for the problems of the elderly. Others say they are in the field because they are responding to a societal need; they came upon the work by chance; they had an intellectual curiosity about work with the aging; or they were assigned the job without choice.

Butler has suggested that the following factors may contribute to a desire to work with the older client:

1) A warm relationship in childhood with grandparents;
2) An early dependence on grandparents;
3) An experience in childhood of the death or illness of an important older person;
4) An unconscious attempt to conquer one's own fears of aging or death;
5) A conscious attempt to prepare for one's own old age;
6) Personal sense of inferiority that causes one to identify with the elderly who are culturally defined as inferior;
7) Guilt for feelings of fear and revulsion toward the aged;
8) Admiration of someone working in the field of aging.

Since an intrinsic element in the entire casework process is the caseworker's relationship with the older client, it is important that the caseworker be aware of attitudes, fears, anxieties, and stereotypes which may be attached to his own particular concept of aging and the aged.

The caseworker must face the fact that some of his attitudes toward the aged may be negative. However, if he makes a conscious attempt to change those attitudes which impede his approaching the client in a constructive manner, he will be taking a big step toward developing genuine respect for the older person.

D. Understanding Loss

The caseworker needs to understand and evaluate the number and kinds of losses the client has sustained and is sustaining in his life. Some of these may be major, some are more easily dealt with. However, added together, they compound each other. For example, a major loss occurs with retirement. The aging adult is separated from regular contact with people, his income is drastically reduced, and the status and prestige derived from his job or occupation are removed. In a society such as ours where a man is measured by what he produces, the cultural devaluation of the worker can be overwhelming. The retired worker feels useless and may become antagonistic about his forced segregation and isolation from the "working" world. Although it may appear that retirement is a time for stopping, actually the reverse is true. The retiree needs to develop a whole new set of skills for coping with fewer friends, lower income, increased amounts of free time. In short, he needs to develop a whole new lifestyle. For those who cannot successfully adapt, the transition can be devastating. If, in addition, other major losses are incurred during this transition, the individual may be permanently maimed. Even minor losses at this time may hamper the ability to adjust.

Other losses the older individual encounters include physical deterioration, separation from friends and relatives due to death or distance, and weakening ties with children, to name a few. Some of the normal changes aging produces have already been mentioned (graying of hair, loss of hair and health, etc.). Pain and illness may also present themselves and hamper the physical functioning and energy levels that are available to the older person.

The death of the marital partner, especially after many years together, represents a major event in a person's life. The mourning process, what to do about the family home and possessions, how to maintain contact with the spouse's relatives, and what to do about new social roles all compound the loss. The deaths of friends, relatives, colleagues, and children are also very difficult to accept. It is not easy to replace a life-long friend; and when close friends are gone, the aged individual may no longer have someone in whom to confide his problems and concerns.

Weakened ties with children may be another loss confronting the aged individual. Although the individual may have already experienced some separation trauma in the form of the "empty nest" syndrome, it is still difficult when the remaining ties to children are attenuated. As children move to another part of the city or country, or become "too busy" with their own lives and children to make time for their parents, the loss is difficult to accept.

These losses are compounded by the aging person's loss of independence. Since entering adulthood, the individual has had a certain amount of independence in choosing a job, living situation, friends, and life style. With old age and the problems which accompany it, the person no longer has the same degree of independence. This is a hard fact for the older person to accept and, in refusing to accept, may hamper the individual from applying to a social agency for help in managing her life even though the situation may be critical. To the older person, this would be an admission of dependence on others for support.

E. Problems of Entering the Casework Relationship

Just as the loss of independence hampers the client from applying for help, the aging individual might also be reluctant to enter into a casework relationship because of fear of rejection. The aged have been rejected more than any other age group - forced out of the labor market and unwelcomed in their children's homes. Thus, they anticipate continued rejection. It is usually only when a situation becomes acute that the aged individual will apply for help on his own behalf or when an application for help is made for her.

Older clients are often characterized as lacking motivation. They do not always follow through on referrals or keep appointments. However, what seems to be a lack of motivation may be a defense against accepting change, both in the process of aging and in patterns of living. It is up to the individual caseworker to determine the nature and strength of the client's ability for change and then utilize these abilities in the treatment process.

F. Casework with Older Clients

The agency. In working with older clients, the agency, as well as the caseworker, must make a commitment to working with the aged. The agency should uphold the policy that serving the aged is an appropriate function of the agency and should assign a high priority to such work within the total agency program. Furthermore, it is important for the agency to develop a method for studying the problems of improving services to the aged through staff meetings, staff development programs, and so on. By doing these three things, the agency will develop a sense of purpose in seeing that the needs of the elderly are met.

The caseworker. From the caseworker's viewpoint, the older client's needs should be the central consideration in providing casework service. Determining the problems that cause those needs, however, is not always simple. Caseworkers are often called into the case when the situation is acute; the caseworker may be pressured by family, friends, or neighbors to act quickly to resolve the case. The feelings of the client, on the other hand, may not be understood by these well-meaning relatives. The older client needs time to get to know and trust the worker. For her own reasons, she may not allow the caseworker to know the entire problem, but rather, may only give out select information. Thus, the caseworker must balance the pressures from the family with the needs and wishes of the client.

Once the problem is defined, the caseworker and client should work together in setting goals. The goals must be realistic, neither too comprehensive nor too restrictive. Caseworkers rarely expect too much from an older client and should be aware of their tendency to see only limited possibilities for growth and change. Granted, some goals may be modest at first, but the caseworker and client should be willing to adjust the goals as time passes if progress is made.

Modest goals include such things as helping the client to be more comfortable with herself; to accept her reality; to improve her self image; to be less disturbing to others; to secure the essentials of everyday living; and to adapt to stress. In work with the older client, caseworkers can be satisfied that their work has served a useful purpose for the older client if it has resulted in the maintenance of adequate functioning, the slowing of the processes of aging, or the relief of stress.

G. Evaluation of the Aged Client

As with any age group, evaluation of the aged client is the basis for setting treatment goals. In the evaluation, the client and caseworker look at the problem, decide what is wrong, and conclude what can be done to alleviate or eliminate the problem. Many factors are examined to determine whether the problem is originating from an internal source, such as from one's physical state or personality or from an external source such as the environment. Since many factors must be examined, it is necessary for the caseworker to be thorough. Certain conditions help to make the evaluation more successful.

A good rapport between the caseworker and client is necessary if the caseworker expects to obtain needed information from the client. In order for the client to be open with the caseworker, the older person must feel that:

1) the caseworker accepts her as a person and is not frightened or disgusted by the physical or mental changes which take place in old age;
2) the caseworker has knowledge of the psychological problems of old age;
3) the caseworker understands the social problems of old age;
4) the caseworker has the professional skills necessary to work with the older person and is empathetic toward her problem.

Confidentiality is a crucial element in gaining an accurate history and in developing and maintaining rapport. The caseworker must recognize the seriousness of protecting the client's privacy. The caseworker has to weigh carefully what facts can be divulged, even to family, without betraying the client's confidence.

The setting and time of the evaluation also influence its success. Although it is not always possible, all persons should be interviewed in a dignified, private setting. Older clients may have hearing difficulties which necessitate a quiet place to converse. Otherwise, the client may be mistakenly assessed. (For a discussion of sensory losses, refer to the module "Ecology of Aging.") It would also be helpful if the older client could be interviewed at mid-day since some clients experience early morning confusion or late day fatigue which could affect an interview. The older person should not be hurried in an interview. In order for the caseworker to elicit as much information as possible, the client should feel relaxed. However, if the client rambles in her replies, the caseworker needs to be able to draw the client back to the topic. The worker must learn to interrupt and to ask questions to give the needed focus. The use of simple and concise language will help the client to grasp the meaning of questions better. The worker should be patient while the client gropes for words or expressions and should not confuse this with rambling.

Often, it is difficult for the caseworker to get the client to discuss her problem. Not all clients will be open, verbal, or even want help. Sometimes if the worker asks about the significance of some object in the room or house, such as a photograph, a prominent figurine, a piece of jewelry, or a handmade pillow or afghan, the older person will talk about herself in relation to the object. This can help the client get over initial fear or distrust of the worker and help future discussion. The important point here is not to discuss the object, but why it is significant to the client. If the caseworker spends a great amount of time engaging in "small talk," the client may feel the worker has time to waste or is more interested in the weather or surroundings than in the client's problems.

Cultural factors are often of considerable significance in the assessment of an older person and are sometimes overlooked. If, for example, the client is in her 80s, the caseworker might benefit from an understanding of the client's environment during her formative and maturational years. However, it is very difficult to project back to the 1880s -1900s unless one is an historian. The caseworker should be aware, however, of the experiences the client has lived through - numerous wars and the Great Depression, for example. The caseworker must also consider differences in national, regional, racial, religious, class, educational, and employment background, and experiences which can account for great variation in the client's attitudes and needs.

During the initial interview with the client, background information such as personal, family, economic, and social history should be collected. Butler has said that the collection of "background information should be done in a manner that ensures comprehensiveness without being rigid." The older person may be the most appropriate person from whom to collect this data, or perhaps the older person's relatives can be enlisted. If the client is capable of answering on her own behalf, relatives should be discouraged from answering for her. Relatives should, however, be involved in the diagnostic process and treatment. Certain material, such as name, addresses, and reason for needing help, naturally should be collected during the first contact. Other background material can be collected in a way that is compatible with the needs and personality of the older person, the working conditions faced by staff, and the setting in which service is being given.

Background information should be placed in a transferable file that can be passed from one caseworker to another, if necessary, or from one agency to another. Sharing information not only saves time, but spares the client from having to repeat herself. Here, again, it is important to bear in mind the ethical consideration of privacy. Thus, it is important to gain the permission of the client prior to sharing the information in her file with other caseworkers or agencies.

Because of the gradual loss of physical capacities and organic deterioration that accompany old age, it is necessary for the caseworker to know the status of the client's health. Physical examinations are not necessary in every case, but medical histories are helpful.

The caseworker needs to be aware of the implications of the medical diagnosis in order to understand what is being observed in the client's behavior and what to expect. Medical histories are often obtainable by telephone from the client's physician. Workers should find out what drugs are being taken, for what condition, and for how long. Older persons sometimes lack knowledge about health, medicine, and their own bodies. Physicians often neglect to explain what medications are for or what possible side effects they may produce. Thus, the caseworker should be alert for signs of physical illness or drug reactions.

Similarly, psychological tests are not necessary in every case. Caution is urged, however, in the opposite direction. When dealing with a crisis situation, the tendency is to concern oneself only with the immediate environment. Thus, the value of the psychiatric view can be overlooked. Psychiatric evaluations should be made if there is uncertainty as to whether a problem is organic or functional; for example, when there is uncertainty concerning the diagnosis of organic brain damage versus depression, testing should be done in order to determine the most effective method of treatment.

An in-the-home assessment is a valuable diagnostic tool for the caseworker. It provides a sense of the client's day-to-day existence. The caseworker should look for signs to determine the client's functioning level. Some things to look for include pets (responsibility for another); calendar (to what month is it turned); clock (is it set properly and running); odors (gas leaks, spoiled food, signs of incontinence); food supply (is there enough food to indicate that the person is eating regularly and adequately). The caseworker can also observe the safety and security of the home and the client's ability to get around the house. These factors help the caseworker put the client's problems into perspective.

Once an evaluation is made, the client should, ideally, be involved in the problem solving process. Some caseworkers treat aged clients as if they were incapable of making decisions. It is important for the caseworker to bear in mind the dignity of the client and the right of the client to make his or her own choices.

H. The Importance of Reminiscing

In working with an older client, the caseworker should be aware of the importance of reminiscing. Reminiscence, defined as thinking about the past and reflecting, can be used by the worker as a positive aid in the interview. Butler has stated that the tendency of the elderly to reminisce has been thought of as indicating a loss of recent memory, and therefore a sign of aging. He postulated, however, that reminiscence in the aged is a part of a normal life review process. According to this concept, realizing that death is an imminent possibility, the older person uses life review as a way of accepting the successes and failures of the past.

Depending on the person, the life review can be mild or extreme. In the mildest form, the person tells stories of the past and verbalizes successes and regrets. The life review can be more severe in others, causing anxiety, guilt, depression, and despair. In some extreme cases, if the person cannot resolve problems or accept them, suicide can result. According to Butler, the most tragic life review is one in which a person decides that life was useless.

However, positive results can also come of the life review. The person can take pride in past accomplishments and feel satisfied. This can produce a sense of serenity in the older client.

It is important, therefore, that the caseworker not hurry the client, but permit time to reminisce. This may be a particularly valuable technique when dealing with a noncommunicative client. By being allowed to discuss a former period of her life, the client may gain the courage to discuss other issues, including the presenting problem.

I. The Worker-Client Relationship

The caseworker needs to be aware not only of his own attitudes and values toward the aged, but also of how the client perceives him. For many elderly clients, the multiple problems of old age and the consequent loss of independence are extremely hard to accept. These older clients grew up during an era when contact with a social agency was considered a disgrace. The caseworker, on the other hand, probably much younger, healthier, more educated, from a different socioeconomic class, supported by family and friends, may find this attitude on the part of the client to be unreasonable.

In his initial approach to many older clients, the caseworker needs to evaluate these differences. The client may react to the worker with anger, rejection, or may not allow the worker to enter the home even though an appointment had been scheduled. The worker may be "tested" by the client in many different ways. The worker should not try, however, to break down these defenses, for they help the client to cope with the stresses of life as she sees them. The worker should persevere until the client is ready to start solving her problems. At that time, when they are no longer needed, the defenses will be dropped.

Some clients see the worker as an authority figure. Even though authority is an integral part of a worker's role, not all workers feel comfortable with the authority they have, nor do they always feel certain of the agency's service parameters. The relationship with the client will be jeopardized if the worker uses too much or too little authority. Authority should be used to help the client develop her own limits by giving the security of structure.

Some older clients want to feel protected by the caseworker. In the absence of family and friends to care for them, they look to the caseworker for support. The caseworker must decide when protection is appropriate and when it becomes overprotection, which can be destructive to the client. Some caseworkers may erroneously assume a protective role when it is not necessary and then be reluctant to do so when it is vital to the welfare of the client.

Caseworkers sometimes fail to realize the impact that they have on clients. They enter a client's life, often meeting with a great deal of initial resistance from the client. Then, an attempt is made to develop a relationship with the client to facilitate implementation of problem solving strategies. Finally, when the problem has been resolved, the caseworker withdraws from the life of the client. The client may see this experience as beneficial or detrimental. Hopefully, the client will grow and gain from the experience. Some clients, however, will feel abandoned and hurt when the worker withdraws. The caseworker must constantly assess what he means to the client. If the caseworker can become more self-aware, the client will be benefitted.

Most caseworkers enter the social work field because they perceive themselves as caring people who sincerely want to help others. If the caseworker can communicate this to the client by demonstrating a conviction in the client's worth, her right to a decent place in society, and her capacity for growth and change, the client will come to trust and respect the worker. In this atmosphere of mutual respect, the task of helping the client solve her problem can be facilitated and, hopefully, there will be a successful outcome to this joint undertaking.

J. References

Bell, B. Significance of functional age for interdisciplinary and longitudinal research in aging. Aging and Human Development, 1972, 3(2), 145-152.

Butler, N., & Lewis, M. Aging and mental health, St. Louis: C.V. Mosby Co., 1973.

Didier, M. The use of self. Paper prepared for a training program in Child Abuse and Neglect; School of Social Welfare, State University of New York at Albany, February-May, 1975.

Dynamic factors in the role of the caseworker in work with the aged. (Proceedings from an institute sponsored by the Central Bureau for the Jewish Aged, October, 1961.) New York: Central Bureau for the Jewish Aged, 1962.

Sibulkin, L. Special skills in working with older people. Social Casework, 1959, 40(4), 208-212.

U.S. Department of Health, Education, and Welfare. The aging person: Needs and services. (Working with Older People, Volume III; DHEW Publication Number HRA 74-3118), 1974.

Wasser, E. Creative approaches in casework with the aging. New York: Family Service Association of America, 1966.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Dynamic factors in the role of the caseworker in work with the aged. (Proceedings from an institute sponsored by the Central Bureau for the Jewish Aged, October, 1961.) New York: Central Bureau for the Jewish Aged, 1962.

This report presents the proceedings of a conference whose major topic areas included basic issues in casework with the aged; dynamic factors in the role of the caseworker in work with the aged; professional attitudes and behavior in social casework practice with the aging; and community organization for services to the aged. Two case histories are presented which were used for the basis of discussion in the proceedings.

Gentry, W.D. Geropsychology: A model of training and clinical service. Cambridge, Ma.: Ballinger, 1977.

This book provides a role model for those professionals who work with the aged. Although written primarily for geropsychologists (psychologists who work primarily with the aged), the book advocates integrating traditional psychological models with skills that are more innovative, such as community care management and government policy. The book contains an analysis of psychological treatment programs for the aged and a curriculum guide for professionals interested in gerontology.

Klein, W.H., LeShan, E.J., & Furman, S.S. Promoting mental health of older people through group methods: A practical guide. New York: Mental Health Materials Center, Inc., 1966.

This book focuses on the need for the community to have workers who are trained in skills and techniques which can help the elderly realize their full potential. The book illustrates ways of helping older people utilize their time in productive ways so as to help alleviate the increasing loneliness that often accompanies decreased activity in old age.

Social group work with older people. (Proceedings of the seminar, "Social group work with older people," June 1961.) New York: National Association of Social Workers, 1963.

This book of the proceedings of the 1961 seminar outlines the socio-cultural, psychological, and physiological factors affecting the elderly. It also explains a plan for group work with the aged and attempts to show how to develop such a program.

Wasser, E. *Creative approaches in casework with the aging*. New York: Family Service Association of America, 1966.

This monograph is written for the direct practitioner who works with older persons and their families. The monograph's purpose is to stimulate creativity in caseworkers' approaches to the elderly client. The material included provides relevant information on a variety of topics: protective services, dealing with losses and grief, placement, overview of casework with the aged, and intake.

B. Periodicals

Blank, M.L. Recent research findings on practice with the aging. *Social Casework*, 1971, *52*(6), 382-389.

This article considers theories and research findings that have meaningful implications for direct social service delivery to the aging. The research cited discusses depression and the aged person's despair, along with a number of helping methods, such as developing an understanding of and interest in the client's life history. This understanding can lead to a better comprehension of the client's problems and desires. Such knowledge is especially useful in helping the aged person make plans suitable to his life patterns prior to the point of crisis.

Brill, N. Basic knowledge for work with the aging. *Gerontologist*, 1968, *8*, 197-204.

This article briefly touches upon four knowledge areas that are meaningful in work with the aged: the scientific method that is used in approaching the solution of problems; the concepts of ego psychology and adaptive patterns; the theories of developmental stages and the tasks accompanying each stage; and the learnings from crisis intervention theory. It also offers ways of implementing this knowledge through communication, assessment, and change.

Milloy, M. Casework with the older person and his family. Social Casework, 1964, 45(8), 450-455.

This article examines the aging process within the context of developmental tasks and shifting role patterns. Emphasis is placed on concomitant treatment considerations, such as the establishment of a professional relationship with the aged client, use of community resources, and involvement of the client's family.

Pincus, A. Reminiscence in aging and its implications for social work practice. Social Work, 1970, 15(3), 47-53.

This article deals with the psychodynamic process of reminiscence in the aged person; its intra- and interpersonal functions are explored, and its positive and negative aspects examined. The diagnostic and therapeutic ramifications of this process are considered within the social work treatment setting.

Scott, A.W. Factors in work with aging clients. Arete, 1974, 3(2), 93-108.

This article attempts to survey some of the factors which impinge on the worker whose client is elderly. It focuses on the demands of and problems with various kinds of social relationships; the difficulties which face the worker in establishing a client relationship; and the system of values subtly affecting work with aged clients. The article concludes with some guidelines and observations on the worker's response to the aged client.

Sibulkin, L. Special skills in working with older people. Social Casework, 1959, 40(4), 208-212.

This article outlines the special skills required in casework with the aging: to use simple and concrete language, patience in listening, and communicating through gesture and posture. It also details treatment goals and techniques and some characteristics of the aging process that caseworkers should be aware of in dealing with older clients.

Wasser, E. The sense of commitment in serving older persons. Social Casework, 1964, 45(8), 443-449.

This article is concerned with the social worker's commitment to serving the older person and to developing the knowledge and skills with which to meet the elderlys' needs. Included in the article are such topics as working with the resistive client and understanding limitations and achievements of clients.

VII. AUDIOVISUAL AIDS

NOBODY EVER DIED OF OLD AGE

16mm film/Color
65 minutes, 1975
Available from: Films Incorporated or Adult Services Project
Rental : $ 45.00
Purchase: 650.00

Working with older people is often much more than putting the frail and weak in institutions, taking care of their biological needs, and being efficient. To work with older people is to develop an empathetic understanding of the individual's needs and desires to live with dignity.

This film dramatizes the lives of a series of resoucefully independent older citizens who are struggling to survive with some degree of dignity. This film is based upon the experiences of Sharon Curtin, author of the best-selling book of the same name.

PASSING QUIETLY THROUGH

16mm film/Black & White
26 minutes, 1970
Available from: Films Incorporated
Rental : $ 30.00
Purchase: 300.00

Working with the aged client can be a rewarding experience, but often is seen as a chore. Old people may be seen as useless, dependent children in need of babying. In this film an old, dying man who is unable to care for himself attempts to bring his life to a meaningful close through his only contact, the visiting nurse who cares for him. Her inability to deal with his needs, other than physical, frustrate them both.

RIGHTS OF AGE

16mm film/Black & White
28 minutes, 1967
Available from: New York State Department of Social Services
No rental fee in New York State

After falling in her home, an elderly widow finds her independence threatened. Good-intentioned community health and welfare agencies persuade her to move to public housing. This film should be helpful in stimulating discussion with respect to intervention. For example, was the client's right respected in making decisions which will affect her own life?

WHEN PARENTS GROW OLD

16mm film/Color
16 minutes, 1970
Available from: Learning Corporation of America or
Syracuse University
Prices on request

Working with the aged client means having to work with the client's family too. In this film, edited from the fine feature film, I Never Sang for My Father, the conflict between filial responsibility and a son's desire to have a life of his own are left unresolved. This conflict provides for discussion of the role of "family responsibility."

VIII. DISCUSSION QUESTIONS

1. Robert Butler, an authority in the field of aging and mental health, has isolated eight common reasons why people choose to work with the elderly.

    A. What factors were important in your decision to work with the elderly? Why?

    B. In what ways do these factors affect the relationship with your clients?

2. If one is to enhance his ability to understand a client, it is useful to become aware of that client's cultural, historical and environmental background, especially with regard to the formative and maturational years.

    In order to properly assess today's elderly client's background, one must be familiar with the environmental factors at the turn of the century or before.

    A. When dealing with a 75-year old client, what differences in values and attitudes do you take into consideration? Why?

    B. How do these values and attitudes differ from those of someone: 1.) 65-years old? 2.) 85-years old?

3. The elderly client is sometimes isolated and lonely and will look to the caseworker as a source of friendship and support.

    A. To what extent should the caseworker develop a personal relationship with her clients?

    B. What constitutes a dependent client?

    C. How would you deal with a client you felt was becoming dependent?

IX. INSTRUCTIONAL STRATEGIES

1) Objective: To develop a sensitivity to the individual differences of the older client.

Method: Arrange for trainees to become participants at functions of senior citizen centers, nutrition program sites, housing developments or nursing homes.

2) Objective: To identify factors important in establishing rapport with the client.

Method: Have two individuals role play a client-caseworker relationship (refer to Appendix 1 for sample cases). Allow each individual the opportunity to assume each role. The caseworker should examine the principles of acceptance, understanding, empathy and concern. The client should examine feelings of fear, anxiety, and unwillingness to accept change. After this has been completed, the two individuals should discuss their attitudes, values, and experiences which may impede working constructively with the aged client. A large group discussion may be convened to explore the dyads' mutual perceptions of each other.

3) Objective: To examine the various methods that caseworkers can utilize to make a comprehensive client assessment.

Method: Videotape a simulated client-caseworker session. Videotape equipment can be secured from local educational institutions; i.e., community colleges, four-year colleges, and high schools. The finished product could be a series of vignettes which would allow an audience to play the role of caseworker to provide feedback on the client's situation.

4) Objective: To empathize with the different kinds of loss commonly experienced by the elderly.

Method: Form groups of not more than 10-12 people. Explain to the group that they are going on a fantasy. The year is 2008. Individuals should close their eyes and contemplate the following questions asked by the group leader: How does your body feel? How is your family? How much energy do you have? What do you find yourself doing? Are you working? In what ways do you find joy? Are you married? How is your sex life?

When everyone is ready, have the group open their eyes and introduce themselves to one another. The leader should call on one person at a time, requesting that each participant introduce himself as he is 30 years hence. If a participant has trouble doing this, wait and support whatever the person can do. After achieving this, discussion can follow on the losses experienced with age and the different methods people use for coping with losses.

5) Objective: To develop an appreciation of the importance of reminiscence as a form of life review and acceptance for the elderly.

Method: Enlist the cooperation of a senior citizen from the community to discuss his life experiences, achievements, and disappointments. If the person could do this before the group, this is the preferred method not only for the group but also for the person. If not, the discussion could be videotaped or recorded. A discussion could follow regarding how the worker felt about using the social work technique. The client should have the opportunity to comment on what meaning the use of the technique had to him.

X. PRE- AND POST-KNOWLEDGE QUESTIONS

1. T or F Ageism is the systematic stereotyping and discrimination against old people.

2. T or F Old age is not considered a developmental stage in the ongoing life process.

3. T or F In working with the aged client, a caseworker must be aware of his own attitudes, fears, anxieties, and stereotypes toward the aged.

4. T or F In retirement, the retiree often must develop a new set of skills for coping with his/her new life situation.

5. T or F The loss of independence can hamper the client from applying for help.

6. T or F Goal setting in the client-caseworker relationship should be a mutual process.

7. T or F The setting and time of the evaluation of the aged client has little influence on its success.

8. T or F Relatives should be involved in the diagnostic process and treatment of the aged client when appropriate.

PRE- AND POST-KNOWLEDGE QUESTIONS/KEY

1. T
2. F
3. T
4. T
5. T
6. T
7. F
8. T

Appendix 1: Sample Cases

MISS B.

Miss B. is 89 years old. She was a school teacher for 46 years, retiring 20 years ago. Never having married, she has lived alone since she was 25 years old. Thus, she has developed a very high degree of independence. Her closest relative, an older sister, died three years ago. Since that time, she has become very isolated from other persons. While she is in relatively good physical health, she is becoming increasingly forgetful. Since Miss B. has always placed great emphasis on her mental functioning, this forgetfulness is especially frustrating to her.

MRS. C.

Mrs. C., 60 years old, has undergone a below-the-knee amputation and is nearly blind as a result of diabetes. She had worked as a restaurant cook while raising her pre-school granddaughter until poor circulation and failing vision forced her out of work into a life dependent upon Social Security Disability, SSI, and ADC-OTG for her grandchild. There are no family supports. Mrs. C's background is marked by poor relationships and disappointments which have left her distrustful of others. This is now becoming an issue in that her physical health is necessitating increased dependence upon others causing anxiety, resentment, and anger.

MR. F.

Mr. F., an SSI recipient, lives alone in a furnished room, and takes his meals in a bar below his apartment. He has spent most of his time in this bar since he became disabled four years ago when he lost his left hand in an accident. He has never been married and sporadically held various unskilled jobs since leaving school midway through the 8th grade. He appears much older than his 62 years and has begun experiencing episodes of weakness and confusion which upset him greatly. He feels he is losing his independence and seems to have given up.

MR. G.

Mr. G., 72, lives alone in a senior citizen housing project. A retired engineer, he was divorced from his wife 33 years ago. Since that time, he has lost most contact with his two sons and their families. While Mr. G. appears to have been rather successful in his career, he expresses much confusion about the value of his contributions. Recently, he has been looking back over his life with feelings of unfulfillment and discontentment.

MRS. M.

Mrs. M. is a 74-year old who has been recently widowed after nearly 50 years of marriage. She has had a very difficult time adjusting to the loss of her husband. This difficulty is expressed by an overall lack of enthusiasm and motivation. She lives in her own home, a rather large two-story house. Because of arthritis in her legs, Mrs. M. has been unable to maintain her house since the death of Mr. M., who had been very helpful around the house.

Mrs. M. has two children. A divorced daughter lives by herself in a city about 150 miles from where Mrs. M. lives. A son, with a wife and three teenage children, lives across town from Mrs. M. While both children are very concerned about their mother, neither is in a position to be of much financial help.

MS. R.

Ms. R., 64 years old, had worked as a waitress for most of her adult life until severe heart problems precluded any further employment. She has had two major heart operations and faces the prospect of more surgery. Her doctor's vagueness as to the exact nature of her problems is causing extreme anxiety which she will not express. She persists in doing strenuous housework and refuses homemaker service in what seems to be an effort to deny her poor health.

MR. AND MRS. T

Mr. T., age 60, suffered a stroke six months ago. While he has made a relatively favorable recovery, his right arm and leg are affected, as is his speech. Thus, his mobility and ability to communicate verbally have been somewhat diminished. He is unable to return to his job as a foreman at a local factory.

Mrs. T., 60, has been very supportive toward her husband. She seems to be willing to go to work to support them, if necessary. However, she has not worked in 30 years and is unsure of her skills.

Mr. and Mrs. T. have no children.

MR. AND MRS. W.

Mr. and Mrs. W., Russian immigrants in their early 70's, have been retired for several years and are living in Senior Citizens' housing on a modest Social Security income. They have always been extremely close and affectionate. Mr. W. has been deteriorating in recent months. There have been signs of failing memory, poor concentration, lessened emotional control, and periods of confusion and inappropriate behavior. Doctors believe that some sort of placement will soon be inevitable. Responsibility for managing their affairs has increasingly fallen on Mrs. W. who is feeling overwhelmed. She refuses to accept her husband's declining faculties and will not discuss the possibility of future placement.

INTERVIEWING AND COMMUNICATION SKILLS

I. Training Goal 171

II. Cognitive Objectives 171

III. Affective Objectives 171

IV. Outline 172

V. Sample Lecture 173

VI. Annotated Bibliography 194

- A. Books 194
- B. Periodicals 196

VII. Supplementary Reading Material 197

VIII. Audiovisual Aids 199

IX. Discussion Questions 203

X. Instructional Strategies 205

XI. Pre-and Post-Knowledge Questions/Key 208

I. TRAINING GOAL

To gain understanding of basic interviewing skills. To become aware of the forms of unspoken communication and of how improved communication skills aid in the interview.

II. COGNITIVE OBJECTIVES

- describe the objectives of an interview
- become familiar with factors important in facilitating clear communication
- recognize the various ways people communicate nonverbally and begin to develop skills in interpreting nonverbal data
- know the various barriers to effective listening
- list the general stages of the interview process
- demonstrate the ability to phrase questions and make statements that will help the client to express her attitudes and feelings and facilitate self-understanding

III. AFFECTIVE OBJECTIVES

- develop a sensitivity to the more subtle, nonverbal messages conveyed by the client
- develop the ability to listen more closely and empathically to the client
- help the caseworker become more comfortable with the interviewing format by preparing him for various situations which might occur during the process
- become appreciative of the feelings of the elderly client, who must relinquish a degree of independence by telling a stranger a private, and frequently painful, part of her life

IV. OUTLINE

A. Introduction

B. Definition and Objectives of the Interview

C. Communication

1. Verbal communication
2. Nonverbal communication
3. Listening

D. The Technique of the Interview

1. Preparatory phase
2. Interview proper
3. Closing the interview

E. References

V. SAMPLE LECTURE

A. Introduction

Whenever two or more people interact, communication takes place. It would be impossible for this communication not to take place unless, of course, all of the senses were destroyed. Without the ability to develop and maintain communication with clients or others, the caseworker would not be able to interview.

The interview is the major means of acquiring information about an individual's problem and situation and of applying treatment. However, the interview process is not limited to clients. The caseworker utilizes the principles of interviewing in almost all of his daily contacts.

Thus, the caseworker must be totally familiar with communication skills and interviewing techniques in order to be effective. These skills are not acquired, however, simply by reading a book or studying theory. They are skills that are developed with experience.

B. Definition and Objectives of the Interview

Interviewing serves a variety of purposes. Nearly all professionals regularly use the interview in daily practice. While novice interviewers may wish there were a list of rules and regulations to follow, unfortunately, there is no single, formal, or definitive method of interviewing. Interviewing takes place between human beings who are much too individualized to be reduced to a formula. Nevertheless, there are certain principles which can be followed in order to better facilitate the interviewing process.

Basically, interviewing is a specialized form of conversation by which experiences, attitudes, and views are exchanged. In an interview, each party can observe the other in order to assess thoughts, feelings, and actions. Ordinary conversation, on the other hand, is usually more informal and spontaneous than an interview, with its subject matter being more of a general nature.

The knowledge to be obtained from each interview can vary widely depending on the problem, the interviewee, and the interviewer. In general, however, the objectives of the interview are:

1. To obtain knowledge of the problem and immediate needs;
2. To gain insight into the values, attitudes, and views of the client;
3. To help alleviate immediate needs and initiate efforts to solve the larger problem.

C. Communication

Although interviewing has been described as conversation, there is more to interviewing and interviewing techniques than questions and answers. In Working with People, Naomi Brill has described the nuances which accompany the spoken word as communication - the transfer of meanings from one person to another. She suggests that in normal communication between two people, only one-third of the meaning is transmitted on a verbal level and nearly two-thirds on a nonverbal level. "Nonverbal communication takes place universally when two individuals meet for the first time, size each other up, and develop ideas of the kind of person with whom they are dealing, whether he is hostile or friendly, weak or strong, concerned or indifferent." Since the major initial task of the caseworker is to develop and maintain communication with his client, it is helpful to understand the communication process.

Brill has delineated eight factors which help to establish clear channels of communication with clients:

1. Attitudes and feelings of both receiver and sender are vitally important.
2. An understanding of the basic similarities and differences between the people involved will determine the extent to which a common understanding and acceptance of modes of communication can be relied upon.
3. The capacities of the persons involved to use both verbal and nonverbal communication media and to interpret the symbols should be understood.
4. The worker should be able to use a variety of means of communication to meet the needs and capacities of his clients.
5. The worker should be able to evaluate the need for repetition and emphasis and ensure feedback

to test comprehension.

6. The worker should use "loaded" words and gestures and symbols only as their meaning is commonly understood and accepted.
7. The tempo of communication should be geared to the client's level.
8. The worker should be aware of ways to eliminate interference both in his own communications and in those of his clients.

1. Verbal Communication

Verbal communication, on the surface, seems to be simple and straightforward. Through words, a person expresses his attitudes and feelings. However, the process of conveying exactly what we mean through words is extremely complex. Differences in language, meanings, and usage of certain words - along with limitations in vocabulary on both the part of the caseworker and client - all contribute to these difficulties.

Because of factors such as fear or anxiety, it may be very difficult for the client to describe his real problem. He may insist that all is well when, in fact, just the opposite is true. Perhaps the client fears the reaction of the listener or perhaps the topic is one which is taboo in the culture. Many people, particularly older people, were raised in different cultures and were taught not to discuss certain issues, such as marital problems or sexual difficulties. Sometimes, because of adherence to a philosophy of "rugged individualism" or a fear of becoming dependent upon others, a person may not be able to accept the need to ask for help from an agency. In such instances, the caseworker will need to rely on what Theodore Reik has described as the "third ear" in order to understand and interpret the true meaning of the client's spoken word.

Besides listening for disguised meanings, the worker should be attuned to shifts in conversation, recurrent references, and inconsistencies or gaps in the client's story. A shift may indicate that the client was revealing more than she desired to at the moment, or again, that the subject was too painful to pursue. Or, on the other hand, the shift might really be a continuation. In the client's mind, the new topic might be integrally related. For example, the client might be discussing her mother and then suddenly make a personal remark about the interviewer. This could indicate that in the client's mind, the worker in some way reminds her of her mother. Very often the recounting of one incident may trigger in the client's mind the memory of another. Sometimes these shifts in conversation are fruitful, for the client relates information the interviewer will need later anyway. This allows the client to proceed at her own pace. At other times, the shift will clearly be a digression, and the interviewer will need to shift the conversation back to its proper channel.

The client might continually repeat a statement or complaint. Recurrent references can be particularly frustrating, since the client is talking, but not moving forward with her story. When such an impasse is reached, the worker must devise ways to get the client to move on. The worker might bring up something related that the client mentioned, but which was not fully explained. In this way, the client is slowly urged on without feeling that her other statements weren't also of value.

In interpreting the client's shifts in conversation or repetition of a statement, the caseworker should assess whether what he is interpreting is correct. He should ask for clarification and feedback on his judgments.

Inconsistencies or gaps might also be noted in the client's story. All too often with older clients, these inconsistencies are attributed to "senility." Although there are organic causes for memory impairment and confusion, the elderly client's behavior may be due to other factors. If the information the client is omitting is needed, the caseworker should try to elicit it. However, if the client does not wish to share the information, she should not be pushed.

Perhaps the significance of the gap or inconsistency will be seen as the case progresses.

2. Nonverbal Communication

Nonverbal communication involves sending messages without the use of words. Nonverbal communication is a continuous process and the principal means by which feelings and attitudes are conveyed. Awareness of nonverbal cues is necessary to assure that a mixed message isn't sent - a contradiction between the verbal and the nonverbal message.

Seldom are we expressionless. Our faces portray a wide range of emotions and reactions, such as caring, disgust, inattention, or doubt. Facial expressions can be used to show the client we understand or are in agreement (smiling or nodding) or can show we don't understand and need clarification (a quizzical look--eyebrows tightened). Good facial expressions on the part of the caseworker match the client's mood and expressed feelings.

The eyes themselves can send several kinds of messages. Meeting someone's glance indicates a sign of involvement, while looking away signals a desire to avoid contact. Establishing eye contact with the client indicates an interest in what she is communicating. Eye contact should be spontaneous, where the listener looks at the speaker but also lets his eyes drift occasionally. According to Brill, "'eye contact' can be a significant factor in assessing the state of mind or feeling of the person with whom the worker is communicating."

Another indication of interest in what the client is saying is posture. It is helpful to lean toward the speaker in a relaxed way. Naturally, the caseworker will position himself in such a way in front of the older client who may have a vision or hearing problem so that the client knows he is there and interested. It is suggested that the caseworker adopt an "open" posture, where he sits facing the client, legs uncrossed, and arms to the sides. This posture should suggest to the client that the caseworker is focusing entirely on the relationship.

Two additional methods of conveying feelings and attitudes are gestures and movements. Gestures can be used to punctuate a statement; for example, pointing to emphasize or signaling to get attention. Movements all too often indicate tension or boredom. Shifting in one's seat, foot tapping, or finger drumming, all point up inattentiveness and should be restricted.

Touching is an important type of nonverbal communication. The society we live in places less importance, however, on touch than on other less immediate senses, such as sight or hearing. Touch is particularly significant to the older client. As people age and become detached from the mainstream of society, and as they experience both personal and social losses, chances for personal contact decrease. Thus, touching becomes a meaningful contact. However, it is important to determine whether the client wants to be touched, for some cultures frown on this.

The way people use space, proxemics, is also part of nonverbal communication. Each of us has a variable size of personal space. Personal space refers to the distance that we put between ourselves and others. There are four distances that we use, depending on how we feel toward the person we are communicating with. Intimate distance is usually reserved for people with whom we feel emotionally close. The zone begins with skin contact and ranges out to about 18 inches. The second zone, personal distance, can range from 18 inches to about 4 feet. Here again, the contact is rather close, but less personal than the intimate distance. Social distance, the third zone, ranges from 4 feet to 12 feet. This is the distance at which most business situations occur or which caseworkers will usually use with their clients. The farthest zone, public distance, runs outward from twelve feet. The closer range of public distance is the one most teachers use in the classroom.

Another way of communicating nonverbally is through vocal quality. Although it may not initially appear as such, vocal quality is definitely a nonverbal skill. Here, emphasis is placed not on what is being said, but on how it is being said. The tone of the voice can convey a range of feelings--anger, surprise, anxiety, disappointment. When working with older clients, the worker must be aware of any hearing problems and adjust the volume of his voice accordingly while still speaking slowly, clearly, and distinctly.

Naturally, any of these nonverbal skills can be overdone, thereby becoming distracting and insincere. For instance, it is not necessary to stare intensely at the client in order to appear attentive. Likewise, too much head nodding can make the client lose his train of thought. These techniques used constructively, however, can be highly beneficial for the worker.

3. Listening

Accurate listening, like verbal and nonverbal communication, is a skill that most people are not taught, though a great many people could benefit from such training. There are a host of explanations for why people do not always attend to what they hear. A very practical explanation is that the sheer amount of exposure to speech which one encounters makes it virtually impossible to attend to all that is heard. Another frequent explanation for poor listening skills is that some people choose not to listen simply because they are more involved with themselves and their own concerns than with the messages someone else is transmitting.

There are different types of listeners. There is the selective listener who listens only to those things which interest him in a conversation, such as a sport or hobby. A selective listener may pretend to pay attention when, in reality, he has little or no interest in what is being said. The insulated listener is one who hears only what he wants to hear and ignores anything that might be unpleasant. The opposite of the insulated listener is the defensive listener. This is the person who interprets anything that is said as a personal attack. Finally, there is the insensitive listener who doesn't interpret messages clearly. As discussed earlier, people don't often express their thoughts or feelings openly but instead communicate through nonverbal cues or through the subtle, unconscious choice of words. The insensitive listener isn't able to hear beyond the actual words, but rather takes remarks at face value.

D. The Technique of the Interview

The first interview should be used to establish the helping relationship between the client and caseworker. The caseworker should explain why he is there, describe the agency he is from, and relate what he hopes will be accomplished in the interview. It is important for the caseworker to point out what the client can and cannot expect from the caseworker. For instance, the caseworker needs to make it clear from the beginning that his intent is to function as a resource person. He does not have "all the answers," and thus, the client should not expect the caseworker to make her decisions for her.

Another important function of the initial interview is that it affords the opportunity for the caseworker to obtain information about the client's background. Historical information, such as family background, problems, social attitudes, and values, can sometimes help the worker to get a feel for where the client is coming from. This understanding is very important in setting up a strategy to resolve the problem.

The client should be given the opportunity to tell her own story at her own pace. Thus, the caseworker will obtain understanding of the client's problem and the client's tempo. Although actual interviews may not follow the stages described below, certain general stages are present in most interviewing situations--the preparatory phase, the interview proper, and the closing.

1. Preparatory phase

The caseworker needs to give thought to the interview before meeting the client. First, he should know the specific reason for the interview in order to plan his method and questions. Second, prior to the interview, as much pertinent information about the client as possible should be gathered. If the case is known to the agency, the case history should be read to (1) avoid duplication of work and to (2) relieve the client of repeating her story. Case histories should be read with caution, however, as biases or prejudices against the client may be present in the history.

When working with aged clients, the place of the interview may be the client's home since not all elderly people can come to an office. This setting has its advantages and disadvantages. The caseworker can assess the living situation, but it might not be as private or dignified as other settings. On the other hand, some offices are crowded or noisy. The caseworker should realize that many fruitful interviews have taken place in settings that are less than desirable, such as crowded subway stations. If the worker is prepared, the setting should not be a barrier to a successful interview, as long as the setting affords the client a certain degree of privacy.

When the caseworker introduces himself to the client and explains his purpose, he should speak clearly and slowly. This allows the client the opportunity to observe the interviewer. The client may be suspicious of the caseworker at first because he is a stranger. Also, the client often needs time because she is uncertain of her own ability to respond to unfamiliar demands. It is important to address the client respectfully as Mr., Miss or Mrs. The use by the caseworker of the first name of the older client is to be avoided, until and unless the client specifically requests such usage. The caseworker should be aware that he might be the only contact the client will have that day; thus, a cordial, friendly smile at first, and other positive facial expressions are encouraged. The caseworker, however, should always be sincere in his approach to clients. A phony smile is worse than none at all.

B. The interview proper

The first step in an interview is to help the client relax and feel comfortable. The client, however, will not be comfortable unless the caseworker himself is relaxed. If the worker is prepared, this should alleviate some of his stress. An advisable next step is to encourage the client to talk. Considerable skill is required with certain clients, and it might take some time before the conversation is free and easy. Thus, it might be wise for the caseworker to assume the lead. But if the client is verbal, much can be gained from letting her talk. As one can see, the problem of approach is a difficult one, particularly if the interviewer was not expected or if the client has had previous negative experiences with caseworkers. It is often a long time before rapport can be established.

Perhaps the central method of interviewing is the "fine art of questioning." A good general rule is to ask questions to obtain specific information or to direct the client's conversation from a non-profitable to a profitable area. Caseworkers should study their own tendencies; too many questions may confuse the older client, while too few may place a burden on her to carry the interview.

Some clients may not respond directly to the questions posed. This can lead the caseworker to think that the client is senile. However, at times an older client might communicate those things about her past or present condition which are most pressing and therefore relevant to her.

It is important for the caseworker to know how to ask questions. The wording of the question is just as important as the manner and tone of voice of the worker who is asking. Brill has discussed various ways of putting words together to bring about desired results:

1. Workers can question and respond in ways that help clients to express and understand feelings and attitudes.
    a) By seeing and putting into words both sides of an ambivalent reaction. ("You are both pleased and displeased with your boy's independence?")
    b) By taking the client's own words and phrasing a question around them. ("You say

you feel funny about adopting a child?")

c) By identifying the attitude or emotion and then taking time to talk about it. ("It sounds to me as if you are frightened. Why does this behavior scare you?")

d) By commenting about what the client is saying and about something he has said or done before. ("And you felt the same way about your first husband?")

e) By accepting silence, encouraging gesture, movement, or murmur.

2. Workers can question and respond in ways that encourage clients to think about and try to understand their situation.

a) By repeating the client's words in the form of a question. ("You never did get along with any teacher?")

b) By asking for further clarification of a statement. ("Did you mean -----?" or "I don't quite understand what you mean.")

c) By restating the main point the client is making. ("You think that the work of the committee is a failure?")

d) By directly inviting the client to express his thinking and feeling on the subject under discussion. ("What do you think is causing the increase in drug use among the young people around here?")

3. Workers can question, comment and respond in such a way that the interview becomes a structured learning situation on ways to look at and deal with problems.

a) By selecting and commenting on the area of greatest concern to encourage the client to focus on and "start where he is." ("You're most uncomfortable right now about Rick's being so unhappy in school.")

b) By questioning and commenting on ways in which the client has attempted to deal with the situation and the results of his efforts. ("You mentioned that your talk with Rick's teacher wasn't very successful -- what actually happened?")

c) By picking up alternatives that the client has suggested or suggesting new ones. ("You had considered asking for a conference with both the teacher and the guidance counselor?")

d) By involving the client in future planning and assigning homework. ("Before we talk on the twentieth, would you like to try setting a regular time for working with Rick, and we can then see how it worked?")

Caseworkers are frequently disturbed by personal questions that clients ask. Often, the worker is embarrassed or unsure whether to answer. If the caseworker can determine the reason why the question was asked, the appropriate response can be made. Personal questions often indicate an effort to establish rapport and may be merely polite or social. Or, the questions may indicate rapport has been established. In most instances a brief and truthful answer will be sufficient, followed by redirection to the client's problem. Clients should not be confused by answers which are too long or too involved.

A client might also ask a question as a way of introducing a problem of his own which is embarrassing. Here again the caseworker needs a "third ear" in order to discriminate. A brief answer should lead into a question about the client's feeling on the subject.

From this discussion, it might appear that the caseworker has little control over the interview. The experienced caseworker may at times feel like a stenographer, merely keeping track of the conversation, while the client selects the topics for discussion, sets the tempo, and directs the interview. The client may very well guide the course of the interview, for the interview is a two-way process. However, at times it is necessary for the caseworker to control the interview to check the flow of the story, to encourage the client to retrace a line of thought, to go back to a point of departure. A statement such as, "I was interested in what you said a moment ago; could you tell me more about that?" will help to bring the conversation back to more fruitful areas.

Silences during the interview should not embarrass the caseworker. These breaks may occur because the client is not quite sure how to formulate what she wants to say. If allowed a few moments, the client may be able to put her thoughts together. Thus, the worker does not need to feel that he must fill these voids with questions or comments. Sometimes, however, the silence is due to other causes and if allowed to continue, can cause uneasiness in the client. In such cases, a pertinent remark or question will encourage her to continue. Caseworkers need to develop the skill to determine which silences are constructive and which are detrimental to the interview.

Similarly, a caseworker might be tempted to interrupt a slow or inarticulate client because of time constraints or the worker's own tensions. Of course, this should be avoided. It might be necessary if the client is proceeding too slowly to let her continue at her own pace and schedule a second interview rather than try to hurriedly accumulate all the necessary information at one time.

3. Closing the interview

Rarely will the client and caseworker feel that one interview is sufficient to obtain all the necessary information to delineate the nature of the problem or to develop a relationship. Thus, the best results will be obtained if the interview is closed before the client is physically or emotionally tired and when she still has something to share. Frequently, a preset time limit helps the client come to closure and avoids last minute confusion. If a natural closing point becomes apparent, however, the caseworker should take advantage of it. Hopefully, the client will suggest another meeting herself, for she will see its value. Caseworkers, however, should not expect this.

Caseworkers often expect a show of gratitude or thanks from the client for their time and efforts and occasionally become resentful when appreciation is not shown. The caseworker, as an empathetic person, must understand what the client has experienced in relating a private story to a stranger. The older client has had to relinquish a degree of her independence, and for many this is extremely painful. Thus, the caseworker should not expect verbal thanks, but can often leave with a feeling of satisfaction in knowing that he might have been of benefit to the client.

E. References

Adler, R., & Towne, N. Looking out/looking in. San Francisco: Rinehart Press, 1975.

Brill, N. Working with people. New York: Lippincott, 1973.

Garrett, A. Interviewing: Its principles and methods. New York: Family Service Association of America, 1972.

Greenberg, L., Fatula, B., Hameister, D.R., & Hickey, T. Communication skills for the gerontological practitioner (Vol. III in a series of programmed training modules on Gerontology), University Park, Pa.: Pennsylvania State University, 1976.

Reik, T. Listening with the third ear. New York: Grove Press, 1948.

Young, P. Interviewing in social work. New York: McGraw-Hill, 1935.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Benjamin, A. The helping interview. Boston: Houghton Mifflin, 1974.

This book emphasizes not only genuine dialogue, but also a vision of the interviewer as an empathic listener rather than as a mere technician. It examines in depth the uses and abuses of questions; contains a chapter on recording the interview; and combines theory and practice with appealing and illuminating anecdotes.

Bingham, W.V.D., & Moore, B.V. How to interview. New York: Harper and Row, 1965.

This book, now in the fourth edition, is addressed to interviewers and to those who utilize the information which interviewers gather. It describes the problems confronting the interviewer and suggests solutions. One chapter deals with the interview in social casework by outlining the kinds of information needed to assess the client's problem and to provide services.

Edinburg, G.M., Zinberg, N.E., & Kelman, W. Clinical interviewing and counseling: Principles and techniques. New York: Appleton-Century-Crofts, 1975.

This book provides a very practical discussion of some of the salient issues in interviewing and counseling. The authors discuss how a working relationship can be initiated, maintained, and terminated. Perhaps the most valuable part of the book is the chapter which covers some of the technical aspects of the interview that are generally not dealt with, such as: lateness, record keeping, personal questions, smoking, and emergencies.

Enelow, A.J. Elements of psychotherapy. New York: Oxford University Press, 1977.

Although written primarily for health professionals, this book provides a general introduction to psychotherapy. Supportive psychotherapy and crisis intervention are discussed and their applicability demonstrated in a broad range of settings. Supportive psychotherapy, for instance, is useful with depressed patients and with patients unable to function socially because of chronic anxiety and depression.

Fast, J. Body language. New York: Pocket Books, 1971.

This book is a good introduction to nonverbal communication and is recommended for people with a casual interest in the topic. Although a bit sensational in style, it is an easy book to read.

Fenlason, A.F., Ferguson, G.B., & Abrahamson, A.C. Essentials in interviewing - for the interviewer offering professional services. New York: Harper and Row, 1962.

This book shows the professional worker how research developments in the social sciences have produced new techniques and information to be used in understanding and working effectively with people. The first part of the book is devoted to a discussion of the meaning of the client's history (cultural background and environment) and how these factors influence the development of the personality. The book also explores how the professional's attitudes can influence an interview. Case studies are used to exemplify techniques of an interview. The book also contains materials for class discussion and assignment.

Garrett, A. Interviewing: Its principles and methods. New York: Family Service Association of America, 1972.

This book, first published in 1942, was written to provide material for in-service training in new and expanding social service agencies. Revised in 1972, the book still serves its original purpose. The book is divided in two parts: Part One discusses the nature of interviewing and Part Two presents illustrative cases.

B. Periodicals

Markson, E.W., & Gognalonus-Caillard, M. Talks with Father William: Senile or sensible? Some problems in interviewing the mentally ill elderly. Journal of Phenomenological Psychology, 1971, 1(2), 193-208.

This article presents some of the problems in interviewing the elderly and gives "how-to" examples using elderly clients.

Schmidt, M.G. Interviewing the "old-old." The Gerontologist, 1975, 15(6), 544-547.

In material drawn from a research study of two homes for the aged, Schmidt points out the kinds of precautions that should be taken and what accomodations can be made when interviewing the elderly. Because of vision problems, other sensory loss problems, chronic confusion, and over-protective relatives, testing instruments should be adapted when interviewing the "old-old."

VII. SUPPLEMENTARY READING MATERIAL

Applebaum, R.L., et. al. *Fundamental concepts in human communication*. San Francisco: Canfield Press, 1973.

Argyle, M. Eye-contact. In D. Martenson (Ed.), *Basic readings in communication theory*. New York: Harper & Row, 1973.

Borman, E.G., & Borman, N.C. *Speech communication: An interpersonal approach*. New York: Harper & Row, 1972.

Carkhuff, R.R. *The art of helping: An introduction to life skills*. Amherst, Massachusetts: Human Resource Development Press, 1973.

Carkhuff, R.R., & Berenson, B.G. *Beyond counseling and therapy*. New York: Holt, Rinehart & Winston, 1977.

Egan, G. *The skilled helper: A model for systematic helping and interpersonal relating*. Monterey, California: Brooks/Cole, 1975.

Egan, G. *Exercises in helping skills: A training manual to accompany the skilled helper*. Monterey, California: Brooks/Cole, 1975.

Frank, L.K. Tactile communication. In D. Martenson (Ed.), *Basic readings in communication theory*. New York: Harper & Row, 1973.

Gayda, G.M., et. al. *Human relations development: A manual for educators*. Boston: Allyn & Bacon, 1974.

Goffman, E. *Behavior in public places*. New York: Macmillan, 1963.

Knapp, M. *Nonverbal communication in human interaction*. New York: Holt, Reinhart, & Winston, 1972.

Laurenson, D. Nonverbal aspects of the interview. In. P. Cross (Ed.), *Interviewing and communication in social work*. Boston: Routledge & Kegan Paul, 1974.

Mehrabian, A. Communication without words. In. D. Martenson (Ed.), *Basic readings in communication theory*. New York: Harper & Row, 1973.

Mehrabian, A. Inference of attitudes from nonverbal communication in two channels. *Journal of Consulting & Clinical Psychology*, 1968, *32*, 248-257.

Mehrabian A. Relationship of attitude to seated posture orientation, and distance. Journal of Personality & Social Psychology, 1968, 10, 26-30.

Satir, V. Communication: A verbal and nonverbal process of making requests of the receiver. In K. Giffen, & B. R. Patton (Eds.), Basic readings in interpersonal communication. New York: Harper & Row, 1971.

VII. AUDIOVISUAL AIDS

ARE YOU LISTENING

16 mm film/Black & White
12-1/2 minutes
Available from: Didactic System, Inc.
Rental: $ 35.00
Purchase: 140.00

This film diagnoses the causes of not listening in order to help the viewer build a more effective communication program. The film explores five major areas of non-listening and provides a firm basis for discussing the effects of non-listening.

CLIENT CENTERED THERAPY - PART II

16 mm film/Black & White
30 minutes, 1952
Available from: University of Michigan
Rental: $5.75

This documentary is of an interview between Dr. Carl Rogers and a client. It shows the 32nd session, where a middle-aged mother expresses conflict with her husband and daughter. There are brief explanatory notes by Dr. Rogers throughout. It is a good example of client-centered therapy at work.

I'M WITH YOU

16 mm film/videotape - Black & White
30 minutes
Available from: South Beach Psychiatric Center

This film discusses the need for the mental health worker to identify and treat with understanding the needs and interests of patients and clients. Through the use of simulated vignettes and actual interviews, the film demonstrates methods of treating troubled, socially inept, and uneducated people to help them gain a realistic perspective on their lives.

JONES - MOHR LISTENING TEST

Audio cassette - 1976
Available from: University Associates
Purchase only: $29.95

This brief and easy to administer test is designed to provide users with immediate feedback on their listening accuracy. The test involves a series of 25 statements from which the listener is requested to identify the emotion of the speaker. Fifty test forms and a facilitator's guide are included with the cassette.

NONVERBAL COMMUNICATION IN NURSING

Filmstrip
Available from: Concept Media
Complete Set (Cassettes or Records) - $300.00
Per Program - $70.00
Instructors Manual - $5.00

"Nonverbal Communication in Nursing" is intended to heighten awareness rather than to instill factual information. The program is divided into five parts:

Program 1 - The Silent Vocabulary

Describes communication as a complex multisensory process which includes both verbal and nonverbal behavior. Stresses the professional's observation and understanding of nonverbal communication as important to successful interaction with clients.

Program 2 - Kinetics: The Study of Body Language

Discusses body language as a socially learned behavior which sometimes expresses emotions more accurately than verbal language; illustrates how facial expressions, gestures, and posture often betray fear, pain, need for reassurance, or feelings of dominance and authority.

Program 3 - Touch

Emphasizes touch as a natural nonverbal expression not only in nursing procedures, but also in communicating care and concern to clients.

Program 4 - Proxemics: Space and Human Experience

Presents principles and theories of proxemics and illustrates how a person's use of space and distance conveys definite messages. Discusses how differences in cultural heritage influence an individual's spatial behavior patterns and stresses the uniqueness of each person's spatial orientation.

Program 5 - Interactions for Study

Dramatizes staff/patient and staff/staff interactions which illustrate the previously taught principles of nonverbal communication. The student has the opportunity to apply what has been learned and begin to make evaluations of nonverbal behavior in realistic situations, aided by discussion guidelines keyed to each interaction.

PERSON TO PERSON COMMUNICATION

16 mm film - 3/4" Video Cassette/Color
14 minutes
Available from: Roundtable Films
Rental: $ 45.00
Purchase: 250.00

This film sensitizes the viewer to the importance of unspoken assumptions, viewpoints, and feelings.

The setting is an employee asking his boss for a week off. The boss is so preoccupied with his own thoughts that he doesn't listen to the employee. A replay permits the audience to hear the thoughts of each participant.

STEP BY STEP: AN INSTRUCTIONAL PROGRAM IN BASIC INTERVIEWING SKILLS

1/2" Videotape/Black & White
Available from: Human Resources Center; University of Texas

This program is comprised of a series of vignettes designed to demonstrate the basic skills of interviewing. Each vignette depicts a dialogue between a counselor and client that illustrates exclusive use of a particular skill. Included are attending behaviors; open and closed questions; expression of content and feeling; reflection of content and feeling; and interpretation.

STUDIES IN INTERVIEWING I, II, III, IV

16 mm film/Black & White
72 minutes, 1965

Available from: University of Michigan
Rental: $17.00

These films, meant to be used sequentially, depict two versions of two situations between a social worker and a welfare applicant. One situation demonstrates poor attending skills on the part of the caseworker. The second part reconstructs the interview using proper attending skills. The series is very helpful in training caseworkers in interviewing techniques.

THREE APPROACHES TO PSYCHOTHERAPY (3 PARTS)

16 mm film/Color or Black & White
118 minutes (Part I - 48 min; Part II - 32 min; Part III - 38 min.)
Available from: Psychological Films, Inc.
Rental: Color - $75.00
Black & White - $60.00
Purchase: Color - $375.00
Black & White - $250.00

This three-part film series allows the audience to view the counseling techniques of the founders of three of the most widely used methods of psychotherapy: Carl Rogers - Client Centered Therapy (Part 1); Frederick Perls - Gestalt Therapy (Part II); and Albert Ellis - Rational Emotive Therapy (Part III).

Each therapist interviews the same client and provides a brief summation. Gloria, the client, evaluates her experiences with the three different therapists.

IX. DISCUSSION QUESTIONS

1. Superficially, verbal communication often seems simple and straightforward; however, two-thirds of all communication occurs nonverbally, and the caseworker who wishes to accurately interpret a client's spoken word must listen with a "third ear."

   A. 1. Do you agree with this statement?
      2. Why or why not?

   B. Give examples of nonverbal cues you have observed for each of the following categories and describe your interpretation of those cues:

      1. Facial Expressions
      2. Eye Contact
      3. Posture
      4. Gestures or Movements
      5. Touching

   C. Can a given nonverbal cue be interpreted in more ways than one?

   D. At what point does one begin to overinterpret the nonverbal language of another?

2. There are many different interviewing styles. Some styles encourage the caseworker to allow the client to set the direction for the interview, while others propose a more structured and controlled format

   A. What kind of interviewing style is most comfortable for you?

   B. Why?

3. "Rarely will the client and caseworker feel that one interview is sufficient to obtain all the necessary information to delineate the nature of the problem or to develop a relationship."

   A. Do you feel that there are situations where it is appropriate for the caseworker to establish a long-term relationship with his clients? Explain.

   B. Is it feasible for you to establish such relationships?

   C. What are your feelings regarding the confidentiality of the interview with regard to caseworkers and superiors.

4. Do you feel that the interviewing/counseling role is an important one for the caseworker? Why? Why not?

X. INSTRUCTIONAL STRATEGIES

1. Objective: To increase awareness of various factors present in the process of observation.

   Method: Instruct trainees to observe an individual or a group unobtrusively. The observation can take place in a restaurant, bar, supermarket, bus station, etc. Trainees observe in pairs and write up separate observations without comparing notes. Have trainees read the parallel papers in class. Discuss the factors which facilitate and inhibit an accurate and objective observation.

2. Objective(s): 1) To increase awareness of the methods used to not listen and 2) To sensitize trainees as to how it feels to be ignored.

   Method: Instruct trainees to form dyads. One partner is to talk about a controversial topic (e.g., capital punishment, abortion, gay liberation) and try to convince the other of his point of view. The other person is to purposefully not listen. After a few minutes, the roles should be reversed. Reconvene large group and discuss the various means used to not listen and explore how people felt when they were not listened to.

3. Objective: To sharpen listening skills and to interpret the true meaning of the spoken word.

   Method: Administer the Jones-Mohr listening test (See VII: Audiovisual Aids for a full description).

4. Objective: To help trainees begin to learn how nonverbal communication works.

   Method: Have group break into dyads. Partners sit back-to-back, making sure that no parts of their bodies are touching.

Once seated, the partners carry on a conversation for about five minutes on whatever subject they wish. Partners then face each other and the conversation is continued for another five minutes. Group should then reconvene and share how they felt in each part of the experience.

5. Objective: To begin to understand distance as nonverbal communication.

Method: Request two volunteers. Each goes to an opposite corner of the room and faces each other. On cue, the volunteers walk toward each other while carrying on a conversation. They are told to stop when only an inch or so apart. They are then asked to back up until they feel they're at a comfortable distance for carrying on conversation. Volunteers share feelings with group and group gives feedback to volunteers.

6. Objective(s): 1) To promote trust and cooperation and 2) To explore the feelings of dependency.

Method: Have large group break into dyads. One partner is blindfolded or instructed to close his eyes. For 10 minutes the pair can sit and talk; the sighted partner can lead the blindfolded person around, etc. Following this, return to large group and discuss the experience and feelings evoked.

7. Objective: To sensitize workers to their feelings, attitudes and belief which can influence the interview process.

Method: Divide the group into triads. Within each group, ask one person to recall a particularly difficult case, one which evoked a great deal of frustration and/or anger. Have this person act out the role of this client. The second person in the triad should function as a caseworker who is meeting with the client. After interacting in these roles for 10 minutes, the third member of the triad, an observer, offers his/her comments about the interchange. Client and caseworker then discuss their feelings about what has transpired. Roles should then be switched, using a different case study, and the process repeated until each participant has the opportunity to function in each of the three roles.

8. Objective: To develop interviewing skills by utilizing the helping process model by Brill.

Method: Break into small groups. Each group decides on a case, either provided by one member or developed jointly from the experiences of the group, and writes a short case summary. Integrating the interviewing skills learned from the module, the group then prepares a report which demonstrates the following:

a. Helping the client begin an interview.
b. Helping the client elaborate on a point.
c. Helping elicit specific behavior to clarify what the client is describing.
d. Helping client focus on her feelings.

XI. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F In normal communications between two people, nearly two-thirds of the meaning is transmitted on a verbal level.

2. T or F Nonverbal communication is a continuous process and the principal means by which feelings and attitudes are conveyed.

3. T or F Eye contact can be a significant factor in assessing the state of mind or feeling of the person with whom the worker is communicating.

4. T or F Touching is not an important nonverbal communication to the older client.

5. T or F The first step in an interview is to help the client to relax and feel comfortable.

6. T or F Questions should be asked to obtain specifically needed information or to direct a client's conversation from a nonprofitable to a profitable area.

7. T or F The wording of a question is more important than the manner and tone of voice in which it is done.

8. T or F A client might ask a question as a way of introducing a problem which is embarrassing.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. T
3. T
4. F
5. T
6. T
7. F
8. T

CASE/CASELOAD MANAGEMENT

I. Training Goal 213
II. Cognitive Objectives 213
III. Affective Objectives 213
IV. Outline 214
V. Sample Lecture 215
VI. Discussion Questions 230
VII. Instructional Strategy 231
VIII. Pre-and Post-Knowledge Questions/Key 232
Appendix 1: Instructional Strategy Worksheet 234

I. TRAINING GOAL

To conceptualize a model of practice called case/caseload management. To enhance the efficient and effective use of time in the provision of services.

II. COGNITIVE OBJECTIVES

- develop a theoretical framework for the utilization of community resources as part of the case/caseload management process

- present a concept of management that is applicable to "handling" cases and caseloads

- describe the notion of delegating and the conditions under which it may occur

III. AFFECTIVE OBJECTIVES

- become aware of how time is being used and the time constraints operating in day-to-day agency life

- develop an identity for social work in the public agency setting

- foster positive interagency relationships through improved interaction

IV. OUTLINE

A. Introduction

B. Casework as a Conditioned Process

C. Caseworker as Case Manager

D. Caseworker as Caseload Manager

E. Implications and Suggestions: Toward a System of Case/Caseload Management

F. Limitations of Case/Caseload Management

G. References

V. SAMPLE LECTURE

A. Introduction

Social work has historically suffered a professional identity crisis in its lack of an unambiguous base for professional development and responsibility. From its early beginnings with charitable organizations, it has grown to claims of full professional stature replete with educational issues and accreditational concerns. The quest of the social work profession for a clear and generally acceptable identity has been hampered by rapidly shifting roles and responsibilities.

This discussion suggests that the forte of social work is the practitioner's ability to successfully move people, problems, and resources about. The knowledge base for this is knowing who pays to provide what to whom and under what conditions.

It is further suggested that the case/caseload management model provides a professional identity for social work by combining its knowledge of human problems with a responsibility for managing the service delivery system.

B. Casework as a Conditioned Process

Perlman describes casework as a process used by certain agencies to help people deal more effectively with problems in social functioning. The core of the casework event is this: a person with a problem comes to or is referred to a place where a professional agent helps with a given process. This helping process, utilizing both direct and indirect strategies of intervention, is conditioned by: the combined effects of open intake policies; wide geographical dispersion of clients; legal and administrative requirements; rising caseloads; and static or decreasing staffing levels.

The "case," which may be loosely defined as a situation requiring assessment followed by some sort of action, is the basic unit of responsibility assigned to workers. A caseload, then, becomes the total number of cases for which a worker has responsibility. Not only are caseloads becoming larger, but perhaps more significantly, changing community needs and expectations regarding the nature of Department of Social Services' responsibilities, vis-a-vis clients, seem to be placing new demands on workers.

Social workers have traditionally operated with a rather cavalier attitude toward management activities, feeling above such mundane concerns. As a profession, caseworkers have paid a considerable price for a disdain for management in human services. This resistance to attempts to specify activities is, in a large measure, responsible not only for the reluctance at all levels of government to fund new programs, but also for the loss of control of existing programs to auditors and cost accountants.

Given the question, "What can be done to enable workers to handle caseloads better?" most caseworkers would respond, "more caseworkers," "smaller caseloads," or "less paperwork". In view of the painfully limited resources of most agencies and increasing governmental insistance upon data collection, none of these solutions are realistic and are perhaps best seen as expressions of concern and frustration.

While workers tend to cast a wary eye at anything with the word "management" associated with it, the hue and cry nevertheless goes on regarding how to "handle" burgeoning caseloads. It is to this precise point of "handling" cases and caseloads that this module is addressed.

C. Caseworker as Case Manager

The question, "How do I 'handle' this case/caseload?" might be restated with an eye to the objectives to be attained by such a process. These objectives are:

1. To direct with a degree of skill that activity referred to as providing services.
2. To achieve some purpose of that activity.
3. To treat with care those problem situations comprising a caseload.
4. To succeed in accomplishing specified service objectives.

All are offered as dictionary definitions of "managing." Management then becomes the "act or art of managing," or the "judicious use of means to accomplish an end," the end being the effective and efficient provision of needed and authorized services to clients comprising a caseload.

It is more the exception than the rule when any single worker or agency can provide all of the necessary services needed by a particular client or clients. In a way, this stands in opposition to one of the faultier professional expectations - that of being "all things to all people." This especially applies to agencies with open intake policies, such as law enforcement, schools, mental health clinics, hospitals, and Departments of Social Services. This expectation reflects two facts of life in the helping professions: people coming for help often have several problems demanding several solutions, and the range of helping technologies has become too broad for any single worker or agency to master and provide.

Few of the people who come for help have well-defined and neatly packaged problems. To the person feeling discomfort and distress, complex physical, social, emotional, and financial problems are often felt as a single burden. Therefore, the primary task of caseworkers is to establish a relationship with the client as a person with multiple problems. Then, the single burden must be broken down into its component parts so that those problems that can be addressed directly can be identified as well as those that must be referred to outside service providers. Obviously, this requires workers to have good interviewing and problem identification skills as well as a thorough knowledge of and familiarity with community resources. It seems that in many cases, workers serve as resource brokers for clients in that they represent the point of entry into a community's service delivery system. That is, once the client is engaged and problems are identified, the worker acts as a clearinghouse of information to insure that appropriate services are provided.

It is clear then that not all casework occurs in direct relationships with clients. The entire range of indirect activities on the worker's part is equally part and parcel of the casework process. For present purposes, this will include all tasks and activities performed by workers on clients' behalf for the purpose of moving toward the objectives of the casework relationship.

Many caseworkers have traditionally acted as resource brokers in linking clients with appropriate resources and/or working cooperatively with other agencies to get the job done. Presently, there is movement on the part of both the Department of Social Services and the Department of Mental Hygiene in the direction of formalizing the resource broker role in which the caseworker becomes the case manager who monitors the total service delivery package. Following intake and initial assessment, the worker as case manager develops a plan of service, arranges for provision of the appropriate services, and then steps back to coordinate and monitor service delivery.

This model of caseworker as case manager frees workers to engage in other vital functions and relieves the agency of heavy investment in limited service programs. Such a model of service delivery is responsive to changing client needs and social environments and considerably expands the range of services that can be made available through a single agency. From the client's perspective, it means not having to search for help in a confusing and overwhelming maze of agencies.

In the case manager role, the worker dispenses a variety of helping services that range from crisis intervention and direct counseling to advocacy, homemaking, friendly visiting, and information and referral. Regardless of who provides the service, the case manager is a clearinghouse for information regarding the type, availability, and accessibility of those services in the community and how to mobilize those resources when they are needed by clients.

Capitalizing on the total resources of the community will enable the worker to spread time more efficiently over the entire caseload. This case management process obviously entails extensive delegation of service tasks. Delegating, however, does not mean abrogating. While the responsibility for providing certain services and feedback may be given to another agency, the responsibility for coordinating the services and following the client through the system still resides with the caseworker assigned to the case. This activity occurs from the intermediate position between the resources of the client and the organized community resources beyond them. Service tasks can be delegated when others can perform them just as well or better, or when the worker cannot perform them at all. Failure to delegate in either or both directions increases the demands on the worker's own resources and hampers efficiency.

So once the problem or problems are identified, the contract struck, and the service plan implemented, the case manager's role is to monitor the effect of the service(s) being provided and to periodically reassess the situation to uncover new information that may alter case objectives or the method of helping. In this view, then, counseling is seen as a coordinating and linking function, with the worker serving as the point of entry into the service delivery system, a broker of resources, and a case manager, while management becomes a process of converting information into action (a process equated with decision-making).

This is by no means intended to discount the more traditional aspects of the counseling function. It is still necessary to engage clients, establish trusting relationships, identify problems, negotiate the helping contract, and work through any psychosocial barriers to service provision. Caseworkers also need to be prepared to utilize crisis intervention skills as they may become involved with the client as the result of a crisis referral or crises may arise during the course of involvement. Likewise, counseling skills are necessary in collateral contacts with family members and friends. But for the purposes of caseload management, counseling is largely a matter of obtaining, processing, and sharing information or of communicating, decision-making, and coordinating activity.

Regular, ongoing client contact may not be necessary in every case. As noted earlier, both direct and indirect strategies of intervention are utilized, producing a subtle shift in role from caseworker to case manager. Once a plan of service is in place and problems have been alleviated, thus producing a stable condition, home visits may be limited to a few situations since, in terms of caseworker as resource broker, other service providers have assumed responsibility for certain specified aspects of the client's well-being. In general, direct client contact is required for: intake and assessment, engaging and contracting, initial follow-up upon implementing a plan of service, crises which cannot be successfully managed by other agencies involved, periodic recertification, monitoring, reassessment, and termination.

In essentially stable situations, the caseworker's primary task is the assumption of overall responsibility for the direction and coordination of services, which is the basis of the worker's relationship to other service providers.

D. Caseworker as Caseload Manager

In the present discussion, case management is viewed as management/coordination within "the case." Caseload management emerges as a monitoring process which enables the caseworker to be aware of the status of given cases on an ongoing basis. This allows for decision-making without direct client contact based on information provided by other agencies. Therefore, caseload management is nothing more than case management exercised over an entire caseload.

The caseload manager coordinates and integrates his or her work with that of other units in the agency and with other agencies in the resource delivery system. He or she also structures and coordinates the diverse activities of several workers to direct their joint efforts in a cooperative fashion toward achieving some significant aspects of service plan goals. Coordination involves some confidence that the different workers and agencies involved understand the service plan objectives in a similar way and accept them. Each worker can operate with confidence that other members of the service delivery team are working together rather than at cross-purposes.

Coordination is the management process which defines and implements the relationship between the activities of different resource providers involved in the service plan. It is the structuring of group activities in a single effort in the implementation of common goals. It is also the integration of different but complementary activities.

The case/caseload management model views the caseworker as broker and coordinator of resources. This perspective both assumes and demands effective intra- and inter-agency communication because, as already noted, management is seen as a decision-making process of converting information into action. Therefore, communication permits effective coordination of the work through linkages which provide a flow of information and feedback.

Communication as a mechanism for coordination is particularly necessary in organizations like human service agencies where activities tend to be ambiguously defined and where frequent contacts are necessary to insure that messages are understood. Effective management requires this active involvement in a clarifying and checking process. Here, the stronger the sense of trust and respect between the case/caseload manager and other resource providers, the more effective the communication. Further, credibility is an important factor in the communication process. There must be a mutual confidence and trust in the motives and genuineness of parties involved that can come only from experience.

E. Implications and Suggestions: Toward a System of Case/Caseload Management

Case/caseload management is not a prescriptive management system for implementation replete with concepts, rules, procedures, and forms. Rather, it is more of an attitude, an approach to getting the job done. It is not necessarily the "right way," but it is one way that can be useful. The following applications stem directly from the preceding discussion, which developed the case/caseload management concept:

1. A clearly defined case management function is generally lacking in a significant portion of interagency caseloads. This tends to produce a situation that can generate a lot of heat, but not very much light. In this view, it is believed that agencies will readily accept formalization of the case management role if the suggestion is made.
2. When making a referral, provide relevant, clear, organized information. Be precise as to what it is you are requesting.
3. Make explicit the nature of your role.
4. Make a joint home visit when another provider makes initial contact. Do this even if their function is evaluation only, since it will strengthen your relationship with that agency and may also be a learning experience for you.
5. Make a follow-up visit after service has begun.
6. Make follow-up phone calls to share information with other service providers and to determine if there are any problems and, if so, their severity.

7. Make periodic contact with other service providers, especially following your home visits/contact with the client.
8. When your client enters another service delivery system (e.g., hospitalization), it is your responsibility to establish a line of communication immediately. This will save duplication and enable you to work together in providing services and coordinating.
9. Ask that other service providers apprise you of problems as they arise.
10. Develop some mechanism (e.g., weekly activity reports) for routine sharing of information to enhance the likelihood that you may identify problems before a crisis stage is reached.
11. Try to know and respect other people's and agencies' limits with regard to what they will/won't or can/can't do and the circumstances under which they will do it.
12. Hold some initial "get acquainted" meetings with other service providers.
13. Make an attempt to learn the resources of your clients' community so that they can be used if necessary.
14. Hold case conferences to provide a means of cooperative problem-solving.
15. The total caseload might be reviewed and some decision made as to those cases on which minimum effort might be expended because the situation is stable. Other cases

might be selected for more intensive consideration. In such cases, either the client may be more vulnerable or the client and the social situation may be open to positive change in response to active intervention by the worker. At the same time, it should be clear where the agency's preferred priorities are (e.g., which cases should receive service if time and energy are limited).

16. To save driving time, assign as many cases as possible in one location of the county to the same worker.
17. It can also be helpful if cases are assigned in the same area of the county where the caseworker lives, which also saves driving time.
18. When going out in the field, the worker should take more cases than he intends to visit in that area. Some clients may not be home or a difficult client may not wish to see you at that particular time. Extra cases prevent the trip from being totally wasted.

F. Limitations of Case/Caseload Management

Case/caseload management will not perform miracles and, as with any system, it has its limitations. Management, like casework, requires more than merely being able to recite concepts; it needs continuing effort. Management is a skill which must be learned and incorporated into the worker's personal style.

There is really nothing magical about case/caseload management. Caseworkers are called upon daily to bring their professional training to bear on a variety of situations in a process called "providing services." This takes place in a constantly changing environment that at times can appear irrational. No sooner is one accountability scheme firmly in place with its attendant forms and training sessions, than another arrives to take its place or exist alongside it. The rules of the game constantly shift, leaving workers and clients to confront the complexities of a system that can give an impression of chaos. In the final analysis, there is nothing but the worker and his creativity and resourcefulness to get the job done.

G. References

Miles, H. W. What information does management need? In *Readings in management*, U.S. Army Logistics Management Center, March, 1971.

Perlman, H. H. *Social casework*. Chicago: University of Chicago Press, 1968.

VI. DISCUSSION QUESTIONS

1. The case/caseload management model assumes considerable interagency activity.

    A) Do you anticipate any problems in working with other agencies as a case manager? If so, what are they?

    B) How might they be prevented or managed effectively?

    C) Discuss the elements of successful interagency cooperation.

2. Caseworkers usually work under appreciable time constraints. Discuss some of the considerations involved in setting priorities.

3. Efforts to clearly define a professional core for social work practice have generally produced ambiguous results.

    A) Does the case/caseload management concept provide a viable model and identity for social work practice?

    B) Do you consider it a professional model?

4. The case/caseload management model is an approach requiring considerable information.

    A) Discuss possible mechanisms for routine sharing of information between agencies.

    B) Are there any implications in terms of confidentiality?

    C) Discuss the nature of the case managers' informational needs.

5. The case/caseload management model proposes some delegation of service tasks.

    A) Discuss the notion of delegation.

    B) Are there any problems with this concept?

    C) What are the types of tasks that might be delegated?

VII. INSTRUCTIONAL STRATEGY

1. Objective: To become aware of the time constraints operating in day-to-day agency life. To help caseworkers plan their time more effectively.

Method: Hand out a copy of the worksheet found in Appendix A and explain that the chart represents a 35-hour work week, 7 hours per day. Instruct trainees to fill in the following on the chart:

- In-office time - set either by agency policy or personal preference
- Intake responsibilities
- Regular staff meetings
- Supervisory conferences
- Hours for case recording
- Hours for paperwork
- Time for phone calls, information and referral, follow-up
- Estimated amount of time necessary for traveling in the field
- Time spent dealing with emergencies
- Any other regular responsibilities

The amount of time left (unfilled hours) represents the amount of time available for direct client contact. Discuss the implications of unfilled hours in terms of how this amount of time can be invested most effectively.

VIII. PRE-AND POST-KNOWLEDGE QUESTIONS

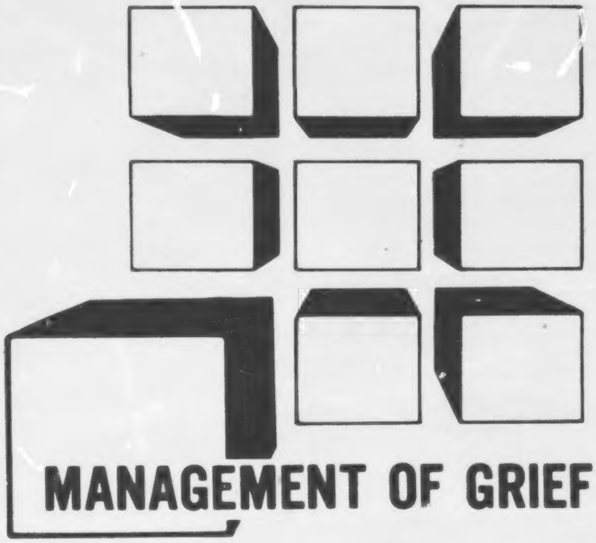
1. T or F The only options for enabling more efficient handling of caseloads are more caseworkers, smaller caseloads, or decreased paperwork.
2. T or F Casework is often more resource brokering than counseling.
3. T or F All casework occurs in direct relationships with clients.
4. T or F The case/caseload management concept expands the range of services available through a single agency.
5. T or F Counseling may serve as primarily a linking function.
6. T or F In delegating, responsibility for following clients through the system passes to the agency to which a referral is made.
7. T or F Management is essentially a decision-making process.
8. T or F The case/caseload manager coordinates and integrates the work of several people and/or agencies.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. T
3. F
4. T
5. T
6. F
7. T
8. T

Appendix 1: Instructional Strategy Worksheet

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY



MANAGEMENT OF GRIEF

I. Training Goal 237

II. Cognitive Objectives 237

III. Affective Objectives 237

IV. Outline 238

V. Sample Lecture 239

VI. Annotated Bibliography 256

A. Books 256

B. Periodicals 259

VII. Supplementary Reading Material 261

VIII. Sources of Additional Information on Death 262

IX. Audiovisual Aids 264

X. Discussion Questions 267

XI. Instructional Strategies 269

XII. Pre-and Post-Knowledge Questions/Key 271

Appendix 1: Role Set Diagram 273

MANAGEMENT OF GRIEF

I. TRAINING GOAL

To present specific information to expand the understanding of dying, death, and grief as experienced by the older person. To explore feelings and attitudes associated with these processes.

II. COGNITIVE OBJECTIVES

- list the factors determining the client's ability to cope with loss
- identify the stages of the grief process and the behaviors associated with each stage
- demonstrate knowledge of Kubler-Ross's stages of dying
- describe ways the caseworker can assist a dying person to create an appropriate death

III. AFFECTIVE OBJECTIVES

- face fears and come to terms with feelings on death and dying
- develop a willingness to understand the client as an individual so as to comprehend those unique factors which determine the client's reaction to loss
- become sensitive to the effects of widowhood - loss and role change
- develop the ability to listen empathetically, offer support, and share similar feelings and experiences with the grieving client
- develop an awareness of the function in the grieving process of rituals which surround death
- understand the sociological factors determining the treatment of death in American society

IV. OUTLINE

A. Introduction

B. The Concept of Loss

   1. Loss as an individual matter
   2. Coping with loss
   3. Widowhood

C. The Process of Grief

   1. Grief and somatic reactions
   2. The caseworker's role in supporting the grieving person
   3. Rituals surrounding death

D. The Dying Process

   1. The work of Kubler-Ross
   2. Assisting the dying client

E. References

V. SAMPLE LECTURE

A. Introduction

The teaching of loss and grief and its related topics, death and dying, can be extremely difficult. Death and the events leading to death have long been taboo subjects for conversation in our society. Recall the euphemism, "He died of a long illness," in place of the dreaded word, "cancer." Recently, however, changes have been noted in the way society behaves toward these topics. The topics of loss and grief and death and dying are given more attention in the educational curricula at all levels--high school, college, and professional schools.

Education in these areas serves to remove misconceptions and fears and helps us come to terms with our feelings on these subjects. Caseworkers with an elderly clientele are in particular need of training in these areas; often the caseworker is in a position to help the client regain a sense of control and mastery of life. The caseworker can help the client strengthen her capacity to cope with the environment. This can only be done, however, if the caseworker knows the subject of death and grief and feels comfortable discussing these topics.

B. The Concept of Loss

1. Loss as an Individual Matter

Throughout life, every person experiences loss--loss of roles, relationships, possessions, and finally, the ultimate loss, one's own life. Of all the losses people sustain, the most difficult to accept is the death of another. At the same time, while some losses may be less painful than others, they tend to reinforce each other. For the older person the losses become multiple: children leave the family home; retirement means not only reduced income but loss of status as well; eventually the spouse and other loved ones die. Finally, the older person anticipates his own death. However, while loss is universal, the effect of the loss on the individual cannot always be predicted. Each individual's life experience is unique and alters both his perception of a particular loss and his personal reaction to it. It is important, therefore, for caseworkers to get to know clients as individuals, to understand what previous losses they have sustained, to know what kinds of support mechanisms they can draw upon--family, community, religious--and to understand their feelings about their own mortality.

2. Coping with Loss

The ability to cope with loss and adapt is determined by three factors:

- The nature of the loss itself
- The nature of the person experiencing the loss
- The nature of the social environment in which the loss occurs

The nature of the loss. The reaction to loss is affected by four conditions. The first condition is when loss occurs. A grown child leaves the parental home, depriving them of her company. Since the loss is seen as appropriate, an adjustment usually can be made. A death following a prolonged illness can at times be viewed by family members as a "blessing." A sudden or traumatic death, on the other hand, finds people unprepared and therefore less able to cope. Some researchers have referred to this as the *timeliness* of loss.

A second factor affecting reaction to loss is *duration*. To a person experiencing separation, the length of time is critical in maintaining hope. Short separations can usually be adjusted to fairly easily while very long separations are much more difficult. A death, which means permanent separation, is thus more difficult than a long period of hospitalization. The most difficult separations are those whose terminations are unknown. During periods of war, for example, families become separated and do not know when or if they will be reunited. This uncertainty is very difficult to adjust to although eventually some type of adjustment is made. Very often, however, the initial reaction to the uncertainty is despair.

The *potential* of one loss triggering another is a third factor. Although all losses may initiate others, some have a higher potential than others. The loss of vision can set off a chain of other events--loss of job, loss of independence, and loss of identity. Thus, while a particular loss might appear objectively to be relatively minor and thus easy to cope with, it is important to recognize that subjectively the person might be suffering anxieties of what could be forthcoming.

The fourth and major factor of the loss is its significance, or the amount of emotional investment the person has made. In this context, an older person who has suffered a variety of losses, such as those that are described above, can invest himself very heavily in a pet or even a physical object. The loss of that object can be very severe, requiring a great deal of adjustment and much understanding on the part of the caseworker.

The person experiencing loss. The character of the person experiencing the loss is the second factor which influences adaptation to loss. An older client who has experienced many painful losses may have diminished adaptive skills. Organic changes can also lessen the person's ability to compensate for the loss. Past experiences and previous coping patterns also influence the way a person will react to a current loss. Clients who have a lower level of adaptability may react in different ways. Some may be unable to express their grief and may exhibit hostility or acute depression. Others may become immobilized and need help with all the decisions of daily living, such as check cashing, grocery shopping, and preparing meals. At this time the supportive environment of the individual may become crucial.

The social environment. The third determinant of reaction to loss is the nature of the social environment in which the loss occurs. The ability to cope is affected by the cohesiveness of the environment, or the extent to which family, friends, and significant others will support or care for the person experiencing the loss. Many older people lack support from the immediate community, such as from churches, senior centers, or clubs. This social isolation makes adjusting to loss even more difficult.

For persons who have a lowered coping ability, the support offered by friends or community becomes even more vital. In those instances where the social support system is inadequate for meeting the needs of the individual, and particularly in the cases of persons with very low adaptive mechanisms of their own, the immobility, depression, or hostility may become so severe that a crisis situation develops. In such cases it may be appropriate or necessary to use protective services for adults to alleviate the temporary situation until the person is once again able to manage on his own.

3. Widowhood

Because life expectancy for women is six to eight years longer than for men and because women tend to marry older men, the frequency of widowhood is high with about half the women over 65 and about two-thirds of those over 75 widowed.

The frequency of bereavement among men, although not as high, is still significant; about one in six is widowed. This fact is often overlooked because men are much more likely to remarry than women, there being more available women in the older population than men.

Although some researchers feel that to the older person the loss of a grown child is the most painful loss, the loss of a spouse is probably equally painful and disruptive to the person's life cycle, if only from the point of view of the amount of time the couple had been together - possibly 30-50 years. Furthermore, the amount of disruption is contingent upon the relationship the husband and wife have had. Families that are tightly knit will be more seriously disrupted. The wife who has always depended upon her husband to make decisions, handle the finances, and so on will be more seriously affected than a more independent woman.

In order to adjust to widowhood, the person must find new roles as an individual. The person must be able to derive satisfaction from sources other than what was meaningful or enjoyable with the spouse. The group that experiences the most difficulty in adjusting to widowhood is the female without children or others to turn to for comfort and support. This group also lacks the flexibility to shift to another role.

Along with role loss, a serious problem for the widowed is loneliness. The death of one's spouse means not only the loss of the object of affection and camaraderie, but also the loss of a life-long sex partner as well. Time passes slowly for those alone and often has little meaning. Loneliness is compounded by poor health; poor health deprives people of the opportunities to interact with others.

People who have socialized as a couple find that they no longer fit in when alone.

Older people cope with loneliness in different ways. Some turn to alcohol in an effort to forget their feelings of depression and hopelessness. Others, particularly white men in their eighties, commit suicide as a final solution to their problem.

Widowhood poses problems other than role loss and loneliness for the bereaved. A problem common for widowers is the lack of skills to maintain a household. Many older men do not know how to select and prepare nutritious foods, clean a home, and do laundry. Women may lack abilities in financial management, decision-making, and more strenuous household chores. This is particularly true in lower class families where there has been a rigid division of labor which distinguishes "man's work" from "woman's work." In addition to all the other problems, there may be significant reduction in income, particularly for women with little Social Security.

C. The Process of Grief

1. Grief and Somatic Reactions

Grief, the reaction to loss, is more than a single emotion. It is a gradual process during which the person suffering the loss must sever his emotional ties to the lost person or object and readapt to the environment and the new set of circumstances. Not all grief occurs immediately following the actual loss. In fact, overt symptoms may be long delayed or may even precede the actual event.

Anticipatory grief may be experienced if, for example, someone close has a long illness. Preparation is made so that when the actual loss does occur, the shock is not as severe. The grief process can be seen as having three stages:

1. short period of shock and disbelief
2. longer period of acute grief characterized by bodily symptoms
3. reawakening to interest in life.

The typical, immediate reactions to a significant loss include disbelief, numbness, and confusion. People are apt to say, "I can't believe he is dead." In an effort to block out the reality of the situation, they may become numb or confused.

As they become aware of the loss and its meaning, the acute grief period begins. Lindemann has described the symptoms common to persons experiencing acute grief. Briefly, they have a tendency toward deep sighing, complaints about lack of strength and exhaustion, and digestive irregularities.

In addition, other emotional reactions are experienced. These reactions may include a sense of unreality; delusions of the presence of the deceased; feelings of guilt for actual or imagined misdeeds; anger and irritability, even toward friends and relatives; disorganization of established response patterns; extreme restlessness and inability to concentrate; anxiety; and depression.

The duration of the grief process is dependent upon how successfully a person does the "grief work." Even persons who are able to reconcile themselves to loss must still do this "grief work." The symptoms of acute grief may last for a month or two; grief work can take another 6 to 12 months. If another loss occurs or additional stress is placed on the griever, the duration may be longer. In this case, a person may sublimate grief and not work it through until much later.

Not all people successfully complete their grief work within this time frame. Delays of months or even years can occur. There are many manifestations of grief; as stated earlier, everyone experiences and perceives loss differently. The person may inhibit his grief in an effort to appear strong or the person may be fixated at the denial stage and never move to resolution. If fixated at a stage, behavior can become exaggerated.

For example, the person may be excessively angry at himself or others, even those most interested in helping him. Or, the person may be so sad and despondent that a depression develops. Maladaptive grieving only serves to delay the person's readaptation to the environment and his return to a more comfortable and satisfying emotional state.

2. The Caseworker's Role in Supporting the Grieving Person

To determine the griever's adaptive level, the caseworker can look for certain physical and behavioral cues. Besides the physical disturbances already discussed (generalized weakness, digestive problems, etc.), behavioral cues, such as disorganization, change in level of activity, excessive use of alcohol or drugs, should be taken into account.

If the griever can be encouraged to talk about his loss, this too will help the caseworker to assess the level of adaptation. However, many people in mourning feel they must maintain their composure, and the best way to do this is to not speak of the deceased. If they can be made to see the importance of talking about the deceased, this may speed their recovery.

The caseworker, naturally, if encouraging the client to talk, must be willing to listen and support the client. The caseworker must convey that he sympathizes with the client's feelings of anger, frustration, guilt, fear or anxiety, and that these feelings are acceptable. In order to do this, the caseworker needs to be the kind of person who has accepted the inevitability of various losses and death and has come to grips, to some extent, with the fact of his own eventual death.

If necessary, the caseworker should be willing to share similar feelings or like experiences with the client. The client might feel as though she is the only one that has ever experienced the pain of grief or that her reactions are unusual. Being able to communicate with another might be helpful.

The caseworker should discourage the client from making any major decisions until she finishes her grief work. At such an emotional time, a decision to move or give away possessions should be postponed. If the client proposes unrealistic plans, the caseworker should suggest alternatives. The caseworker should be positive and emphasize the person's resources and remaining potential.

Friends and other family members may try to protect the griever by not mentioning the deceased or by distracting the person with forced cheerfulness. This practice may actually stunt the person's ability to do his grief work. Caseworkers should explain the importance of letting the griever express her loss to the family and urge them to discuss the loss and it's significance with the griever. However, just as the primary griever wants to appear strong, so do other family members. Thus, work with the family may at times be difficult.

3. The Importance of the Rituals Surrounding Death

Although the rituals accompanying death are today being modified, and in some cases abandoned as unnecessary or archaic, they may still be significant to the older person whose upbringing and culture are different from those who are younger.

The most significant ritual accompanying death is the funeral. A widely quoted definition of a funeral is "an organized, purposeful, time-limited, flexible group-centered response to death." Funerals, however, can be much more than this.

Funerals provide a set of behaviors for the griever to follow. They also help to underscore the reality of death. The visitation period at a funeral home or church points up the reality of the situation and provides a climate for grieving. The funeral helps to bring people together to support the griever at a time of need. The funeral also serves as a "transitional bridge"; the reality of the situation is reinforced, but the person also becomes aware the she has to go on living and under new circumstances.

Traditionally following the funeral is the ritual of mourning. The mourner follows a prescribed set of behaviors - dresses in black; does not participate in certain activities. These behaviors give mourners the opportunity to slowly adjust to their new life situation.

Of course, customs and rituals surrounding death vary according to the bereaved's ethnic group or culture. For example, Italian people tend to be very traditional. Older widows may dress in black for the remainder of their lives following the death of a loved one. Some Irish people view death as a time for conviviality and their party-like wakes attest to this. Regardless of the procedure, the funeral and other ceremonies surrounding death serve a valuable purpose which may not be lightly abandoned.

D. The Dying Process

The survivors are not the only ones who must deal with loss. The ultimate loss is sustained by the dying individual.

Elizabeth Kubler-Ross has done some pioneering work leading to an understanding of the process of death. This kind of understanding may enable caseworkers to offer support at what has come to be known as another stage in the life cycle

1. The Work of Kubler-Ross

In recent years because of scientific and technical advances, people have been moved to hospitals or other institutions to await death, unlike formerly when people died surrounded by family members. Seeing death is therefore not a common experience. Death and dealing with the emotions surrounding death have been turned over to "professionals." And by the time family and friends see the dead person, the body has been embalmed and looks "lifelike" again. Death, therefore, remains a mystery, unexperienced and uncomprehended. The professionals, however, who are assigned the task--the physicians, nurses, long-term care administrators, funeral directors, and social workers are very often no better prepared to deal with either the dying person or the grieving family than the layman.

In an effort to rediscover and to explain to the public and professionals what dying is like, Kubler-Ross has talked widely with people near death and those who have clinically experienced death. In her best selling book, On Death and Dying, she attempts to sensitize the public to the needs of chronically ill patients who in many instances are treated as though they are already dead.

Kubler-Ross has hypothesized that the dying go through five psychological stages prior to death. The dying do not necessarily have to progress through these stages in this order; some may skip one stage or vaccillate between stages. Thus, the stages should not be looked at as absolute or distinct, but rather, seen as levels of experience during the course of dying.

The first stage is denial of death; the person simply refuses to believe that he is going to die. In the second stage, denial is replaced by anger as the person fights against the injustice of his life's ending. After this, the person moves to a period of bargaining, during which he tries to make a deal with God or fate in return for his life. The person might make promises to be a better person, to show more concern for others, and so on. When this proves futile, the person enters a period of depression over the loss of life and loved ones. In the final stage, the person comes to accept his impending death. Acceptance, as used here, does not mean that the individual has come to approve of his impending death. Rather, in this stage, the person is able to approach death with a feeling of quiet contemplation. With this can come a lessening of interest in the material world and one's loved ones.

Kubler-Ross has found that for several reasons persons are very often left to cope with their dying alone in anguish, not knowing what to expect. They are avoided, never touched nor looked in the eye. Decisions are made for them, and they are openly discussed by others as if they were already dead.

Often, family and friends are trying to "spare" the dying individual, or they may be trying to protect themselves from hurt by avoiding the issue of impending death. Very often, however, for the reasons just stated, they simply do not know how to deal with death and what is expected of the living. Encouraged to maintain open communication, family members can aid their own grieving process as well as aid the dying member.

2. Assisting the Dying Client

For the caseworker with elderly clients, it is important to try to understand what individuals might be thinking as they feel they are nearing death. Studies have shown that younger men worry most that they will no longer be able to care for their dependents. Younger women worry most that they will be the cause of grief to friends and family. Both of these worries diminish with age, however, since older people have far fewer people dependent upon them, and they are aware of their reduced impact upon others. To an elderly couple, however, the impending loss of a spouse can be tragic indeed, and both worry about the effect of their own death on the remaining partner.

Pattison describes six ways by which a dying person may be assisted to create an appropriate death. These ways are by:

1. Sharing the responsibility for the crisis of dying... so that the patient has help in dealing with the

first impact of anxiety and bewilderment.

2. Clarifying and redefining the realities of the day-to-day existence which can be dealt with by the patient.
3. Making continued human contact available and rewarding.
4. Assisting in the separation from and grief over the realistic losses of family, body image, and self-control, while retaining communication and meaningful relationships with those who will be lost.
5. Assuming necessary body and ego functions for the person without incurring shame or deprecation, maintaining respect for the person, and helping him maintain his self-respect.
6. Encouraging the person to work out an acceptance of his life situation.

Resolving loss is a long and painful process. Generally, however, people who are supportive are of great value to those grieving. The caseworker may often be in a sensitive but influential position when working with a grieving client. However, caseworkers should also realize that at times a client might need the help of a professional whose specialty is helping resolve their grief. They should assist the client in securing this help and support them during their therapy.

E. References

Berardo, F. Widowhood status in the United States: Perspectives on a neglected aspect of the family life cycle. The Family Coordinator, 1968, 173(3), 191-203.

Butler, R., & Lewis, M.E. Aging and mental health. St. Louis: C. V. Mosby Co., 1973.

Feifel, H. Death in contemporary America. In H. Feifel (Ed.), New meanings of death. New York: McGraw-Hill, 1977.

Henwedge, R., Jackson, M., John-Lilly, E., & Kneisel, K. (Eds.), Loss and grief. Costa Mesa, California: Concept Media, 1977.

Kalish, R. Dying and preparing for death: A view of families. In H. Feifel (Ed.), New meanings of death. New York: McGraw-Hill, 1977.

Loether, H. Problems of aging. Belmont, California: Dickenson Publishing Co., 1967.

Lindemann, E. Symptomatology and management of acute grief. American Journal of Psychiatry, 1944, 101, 141-148.

Patterson, R.D. Grief and depression in old people. Maryland State Medical Journal, 1969, 18, 75-79.

Pattison, E.M. Help in the dying process. Voices: The Art and Science of Psychotherapy, 1969, 5, 6-14.

Phillips, D.P., & Feldman, K.A. A dip in deaths before ceremonial occasions: Some new relationships between social integration and mortality. American Sociological Review, 1973, 38, 678-696.

Raether, H., & Slater, R. Immediate postdeath activities in the United States. In H. Feifel (Ed.), New meanings of death. New York: McGraw-Hill, 1977.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Feifel, H. (Ed.) *New meanings of death*. New York: McGraw-Hill, 1977.

This book, a revised edition of *The Meaning of Death* (1959), is a collection of readings about many facets of the processes of death and dying: developmental orientations, clinical management, survivors, and responses to death. Contributors include Robert Kastenbaum, Edwin Shneidman, Richard Kalish, and Daniel Leviton.

Grollman, E.A. (Ed.) *Concerning death: A practical guide for the living*. Boston: Beacon Press, 1974.

This book, written in a question and answer format, provides much practical information about topics such as grief; children and death; religious perspectives on death and mourning; legal aspects of death; funerals; burial and cremation; suicide; and death education. The chapters which differentiate between Protestant, Roman Catholic, and Jewish customs and rituals are quite informative. A good basic reference for helping professionals who deal with death.

Kart, C.S., & Manard, B.B. (Eds.) *Aging in America: Readings in social gerontology*. Port Washington, New York: Alfred, 1976.

This collection of readings in social gerontology contains a very good section on death and dying. Among the death-related topics covered are socialization for death, ritualization, dying and the elderly, and dying as a "career" in the nursing home setting.

Kubler-Ross, E. *On death and dying*. London: MacMillan, 1969.

This book is one of the most widely read books on dying, death, and the terminal patient. Dr. Ross's pioneering work in interviewing terminal patients and describing the five stages of dying has become the foundation for much of the current interest in these topics.

Kastenbaum, R.J. *Death, society and human experience*. St. Louis: C. V. Mosby Co., 1977.

Death is examined by Kastenbaum as a transitional event rather than as a developmental stage of life. This helps to provide some insight into care given dying persons. Also included are excellent chapters on bereavement as a process, grief and mourning and a complete list of additional reading.

Lopata, H.Z. Widowhood in an American city. Cambridge: Schenkman Publishing Co., 1973.

The increasing number of American widows and the loss of roles characterized by widowhood prompted this detailed study of widowhood. The book begins by discussing the theoretical and sociological issues surrounding widowhood, and then examines in depth various aspects of the study group: characteristics, social roles, friendships, community relationships.

Parkes, C.M. Bereavement: Studies of Grief in Adult Life. New York: International Universities Press, 1973.

This book provides an authoritative description of what is known about grieving in both its healthy and less healthy forms. It also is a guide for professionals whose work brings them into contact with bereaved people. An excellent list of references and national organizations offering help to the bereaved concludes the book.

Peterson, J.A., & Bri[illegible]ey, M.L. Widows and widowhood: A creative approach to being alone. New York: Association Press, 1977.

This book addresses itself to the economic, social, and psychological problems of widowhood. As part of a comprehensive look at ways in which the widow can enrich her life, much of the literature on death and dying, grief work and education is incorporated. The book utilizes interviews, research, and case studies in presenting the material and is relevant not only to widows but also to those suffering from separation trauma.

Pincus, L. Death and the family: The importance of mourning. New York: Pantheon Books, 1975.

This book, through the use of personal memories of the author and some theory, explores the patterns of grief and mourning. It focuses on some aspects of bereavement which have been identified in other studies, such as the process of mourning and grief and the phases of adaptation, as well as repressed mourning, which will be useful for the bereaved and caseworker to understand.

Sell, I. L. Dying and death - An annotated bibliography.
New York: Teresias Press, 1977.

This book contains 506 annotations of articles, books, and audiovisual materials pertaining to dying and death. It was prepared primarily for nursing practitioners, educators, and students involved with providing care for dying patients.

Switzer, D. K. The dynamics of grief. Nashville: Abingdon
Press, 1970.

This book examines the theory and philosophy behind the concept of grief and the anxiety and paradox grief brings to the bereaved. The book provides a unique review of the literature and devotes attention to pastoral care of the bereaved.

B. Periodicals

Berardo, F. M. Widowhood status in the United States: Perspectives on a neglected aspect of the family life-cycle. *The Family Coordinator*, 1968, *17*(3), 191-203.

This article examines selected socio-demographic conditions which characterize contemporary widowhood status, such as loss of income, necessity to seek employment, problems of orphanhood, and problems of personal adjustment and mental health.

Engel, G. L. Grief and grieving. *American Journal of Nursing*, 1964, *64*(9), 93-99.

This article describes the normal grieving process and suggests ways to help the grief stricken.

Gramlich, E. P. Recognition and management of grief in elderly patients. *Geriatrics*, 1968, *23*, 87-91.

This article examines the process of grief in general, paying particular attention to grief among the aging. The author defines grief in its typical and atypical forms and provides insight to the management of grief. Although written by a physician for physicians dealing with grief among their patients, the article is relevant to caseworkers.

Jeffers, F. C., & Verwoerdt, A. How the old face death. In E. W. Busse & E. Pfeiffer (Eds.), *Behavior and adaptation in later life*. (2nd ed.). Boston: Little, Brown and Co., 1977.

This article focuses on the coping mechanisms used by elderly people in the prospect of death. It also describes the personal meaning attributed to death and emotional reactions to death awareness.

Kalish, R. A. Dying and preparing for death: A view of families. In H. Feifel (Ed.), *New meanings of death*. New York: McGraw-Hill, 1977.

This article explores the meaning of death and the dying process for persons of differing ages. The death of older persons is seen as less tragic than the death of persons of any other age group.

Lindemann, E. Symptomatology and management of acute grief. American Journal of Psychiatry, 1944, 101, 141-148.

This article describes the symptomatology of normal and morbid grief,as well as prognostic evaluations of grief. It also outlines psychiatric management of grief work.

VII. SUPPLEMENTARY READING MATERIAL

Feifel, H. (Ed.). The meaning of death. New York: McGraw-Hill, 1959.

Fulton, R. Death and identity (2nd ed.). New York: Wiley, 1976.

Gorer, G. Death, grief and mourning. New York: Doubleday, 1965.

Hinton, J. Dying. Baltimore: Penguin Books, 1967.

Kastenbaum, R. The psychology of death. New York: Springer, 1972.

Kreis, B., & Pathe, A. Up from grief: Patterns of recovery. New York: Seabury Press, 1969.

Morris, S. Grief and how to live with it. New York: Grosset and Dunlap, 1972.

Schoenberg, B., Carr, A.C., Peretz, D., & Kutscher, A.H. (Eds.). Loss and grief: Psychological management in medical practice. New York: Columbia University Press, 1971.

VIII. SOURCES OF ADDITIONAL INFORMATION ON DEATH

The University of Minnesota
Center for Death Education and Research
1167 Social Science Building
Minneapolis, Minnesota 55455
(612) 376-3641

The Center undertakes a broad spectrum of projects and programs to contribute to a greater understanding of the issues related to death and dying.

It provides community and professional education by sponsoring four symposia on various aspects of death, grief, and bereavement. A cassette tape library consisting of lectures, interviews, and panel discussions is available. Information concerning the 24-tape program is available from the Center or the distributor, Robert J. Brady, Co., Bowie, Maryland, 20715.

The Center produced ten video programs for community television on topics such as death in American society, the denial of death, grief, the funeral, the role of professionals, and ethical issues. These programs are available for rental from the Department of Continuing Education at the University of Minnesota.

The Center has numerous publications available for purchase, such as:

Death and Identity (2nd Edition), Robert Fulton (Ed.), 450 pages.
Bibliography on Death, Grief and Bereavement: 1845-1975. Contains over 3800 references. Available from the Center or Arno Press, 330 Madison Avenue, New York, New York 10017.

The Foundation of Thanatology
Dr. Austin H. Kutscher, President
630 West 168th Street
New York, New York 10032

The foundation is devoted to the scientific and humanistic acquisition and application of knowledge concerning: psychological aspects of dying, reactions to death, loss and grief, and recovery from bereavement.

In conjunction with other agencies concerned with the dying and bereaved, the foundation conducts a variety of symposia and workshops.

Concept Media
1500 Adams Avenue
Costa Mesa, California 92626

This audiovisual production center offers a variety of training and educational materials on aging and death, dying, loss, and grief. All filmstrips come complete with instructor's manual, discussion tools, and bibliographies. Previews are available upon request.

IX. AUDIOVISUAL AIDS

DEATH

16mm film/Black & White
43 minutes, 1969
Available from: Filmmakers Library, Inc. or University of Michigan

This film presents an intensely personal portrait of a 52-year old man dying of cancer at Calvary Hospital in New York City and presents the response of family, hospital personnel, and other patients. It asks why it is so hard to communicate in a meaningful way with the dying and asks what psychological defenses are used by the patient in his last moments.

THE FINAL PROUD DAYS OF ELSIE WURSTER

16mm film and Videocassette/Black & White
58 minutes, 1975
Available From: The Pennsylvania State University
Rental: $14 - film $7.50 - cassette

Filmed in a central Pennsylvania nursing home, this observational documentary concerns the final thirty days in the life of Elsie Wurster. Mrs. Wurster is observed with visitors and friends as she takes therapy and treatment and talks about her feelings, fears, and memories. This film is a sensitive and moving portrayal of a courageous person.

MINNIE REMEMBERS

16mm film/Color
5 minutes, 1975
Available from: Mass Media Ministries
Rental: $12.50
Purchase: $125.00

This short film is based on the poem "Minnie Remembers" by Donna Swanson. Minnie, an old woman, sits all day in her rocking chair and reminisces about her past. Minnie tries to remember the last time someone touched her. In her 20 years of widowhood, she has been respected, smiled at, but never touched! The ultimate tragedy, the loss of one's identity, is beautifully portrayed in this short and yet poignant film.

PASSING QUIETLY THROUGH

16 mm film/Black & White
26 minutes, 1970
Available from: Films Incorporated
Rental: $30.00

This award-winning film is about the death of an old man. Bedridden in his run-down apartment, he is cared for by a cynical nurse. Their exposure to one another develops into a relationship based on truth and mutual trust.

PEEGE

16 mm film/Color
28 minutes, 1974
Available from: Phoenix Films and Adult Services, Continuing Education Project
Rental: $40.00

Peege, an old woman in a nursing home, is visited by her son and family. One of the grandsons is able to arouse a momentary spark in his grandmother while the other family members cannot. The film conveys the dignity of the old woman knowing that someone cares and the importance of such feelings at any stage of life.

THE RIGHT TO DIE

16 mm film/Color
56 minutes, 1974
Available from: The University of Michigan
Rental: $22.00

This film explores that intensely personal subject of universal concern, once considered taboo and still regarded as delicate in American society: death. In face-to-face interviews with courageous dying patients, ranging from a boy of 12 to older men and women, the film touches on such questions as "hopeless" medical situations, recent technical means for prolonging biological existence, solutions such as mercy killing and suicide, and the ability and best means for physicians and clergymen to deal with dying patients. The film indicates that society is at last making strides, if not in conquering death, at least in facing it.

TO DIE TODAY

16 mm film/Black & White
50 minutes, 1970
Available from: University of Michigan or Filmmakers Library, Inc.

Rental fee on request
Previews available

Dr. Elizabeth Kubler-Ross explains her theories that advocate a more enlightened approach to the care of the dying. She discusses the five emotional stages which patients generally pass through and explains how sensitivity to these stages is essential in relating to the dying patient.

WHAT MAN SHALL LIVE AND NOT SEE DEATH

16mm film/Color
57 minutes, 1971
Available from: Films Incorporated or University of Michigan

There is a "conspiracy of silence" surrounding the subject of death. Through conversations with doctors, clergymen, terminally ill patients and bereaved people, the silence is lifted. This study of death and how Americans deal with it provides insight into a profound and universal experience. Produced by WNBC-TV, this film has won many awards including TV's Emmy.

X. DISCUSSION QUESTIONS

1. It is said that death is a natural part of the life cycle.

    A) Do you accept this statement?

    B) Why should we talk about death, if at all?

    C) What is your philosophy of death?

2. As a caseworker, you may be in a position to support a grieving person.

    A) Would you feel comfortable in this role?

    B) Is it an appropriate role for a caseworker?

3. At some point most of us have been in a position to comfort a friend or relative who has experienced the loss of a loved one.

    A) Can you recall how you have supported grieving relatives or friends?

        1) Describe the experience.
        2) How did you feel?

    B) Have you experienced the loss of a loved one? How did your experience compare with the grief process discussed in the module?

4. Increasingly, professionals will be called upon to help the terminal patient accept death. To be effective, the death counselor should be "empathetic, genuine, trusting, respectful, and ready to invest himself in the emotional struggles of someone who faces the loss of everything that has ever had meaning."

    A) How do you react to this statement?

    B) How would you feel about counseling a dying person?

5. Although the rituals surrounding death are being changed and in some cases abandoned as unneccessary, they may still be significant to the older person, providing a set of behaviors for the griever to follow and underscoring the reality of death.

    A) What would you like done for your death?

B) Explain your choice, placing special emphasis on how this choice might facilitate or hinder your loved one's management of grief.

6. The extent to which people can intervene in their own dying process is far from understood. In an attempt to document the will-to-live, Phillips & Feldman (1973) looked at dates of death in relationship to birthdates and important holidays. They found that significantly more people died shortly after these occasions than died in the equivalent period prior to the date. One interpretation of these results is that a will-to-live was operative. Conversely, the will-to-die is often described by workers in long-term care facilities and elsewhere following the death of an elderly resident subsequent to some particularly depressing event.

A) Discuss whether people can intervene in their own dying process. Is there a will-to-live and a will-to-die?

B) In the film, "The Final Proud Days of Elsie Wurster," did Elsie have a will-to-die?

XI. INSTRUCTIONAL STRATEGIES

1. Objective: (1) To stimulate discussion of the various aspects of death; (2) To make participants aware of the range of professionals available to help the grieving or dying.

   Method: Invite a panel composed of clergy, physician or nurse, funeral director, long-term care administrator, counselor.

2. Objective: To help participants face the inevitability of their own deaths and the deaths of others. In this exercise, each participant will probably relate those things which they would value for themselves in their own deaths.

   Method: Have participants break into small groups. Groups can select from planning a funeral, writing an epitaph or writing a eulogy for a person known to all or a person in the group who has been pronounced "dead."

3. Objective: To reinforce the reality and finality of death.

   Method: If possible to find, invite a person with a terminal illness and a person who has recently experienced a death to talk with the group.

4. Objective: To stimulate discussion on the timeliness of death and Kubler-Ross's five stages of dying.

   Method: In large group, leader asks for three volunteers. "A" is told he has been shot and has died instantly; "B" is told he has been mortally wounded; "C" is told that he is soon to die.
   Large group breaks into small groups. One group attends "A's" funeral while the other two groups counsel the dying "B" and "C". Groups can then rotate so that each group deals with "A", "B", and "C".
   Small groups reconvene. "B" is to die and large group discusses feelings. "C" prepares a self eulogy. Group can discuss with "C" the five stages of dying and whether he has reached the fifth stage, acceptance. "C" is then told he has died. Group can discuss and share feelings.

5. Objective: To stimulate discussion on personal role patterns and the possible effects of loss of roles.

Method: In large group, leader distributes copy of Appendix 1. Trainees are instructed to select among the roles those which they fill and then divide the circle into parts depending on how important each role is to them (50%, 25%, etc.). The entire circle should be filled in with roles. Leader collects the role charts. Trainees break into small groups. Each group is then given the appropriate number of charts and discussion follows. The following questions are suggested guidelines:

1. - does the person play a variety of roles?
2. - does one role dominate the person's life?
3. - what would happen if the dominant role were lost?
4. - how might lost roles be replaced?
5. - what would a chart look like if the person were retired?*

*Adapted from: Steib, G. F. Retirement roles and activities. White House Conference on Aging, 1971.

XII. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F A person's ability to cope with death is closely related to the timeliness of that death.

2. T or F One of the strengths of the older client who has experienced many losses is her increasing acceptance of death and, consequently, her ability to adapt to such loss.

2. T or F Dying persons are often left to cope with death alone due to the family's inability to deal with the subject.

4. T or F One can help create an appropriate death by encouraging the dying person to accept her situation.

5. T or F Many rituals surrounding death tend to distort and avoid the true impact of the event.

6. T or F The caseworker supporting the grieving person should prevent the client from being preoccupied with the loss.

7. T or F It is important for the caseworker to help the grieving client concentrate on making plans for the future in order to facilitate movement through grief work.

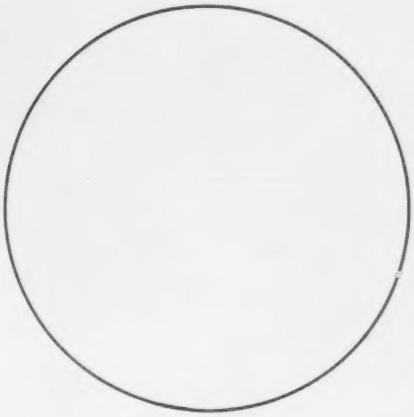
8. T or F In order to adjust to widowhood the person must find new roles as an individual.

PRE- AND POST-KNOWLEDGE QUESTIONS/KEY

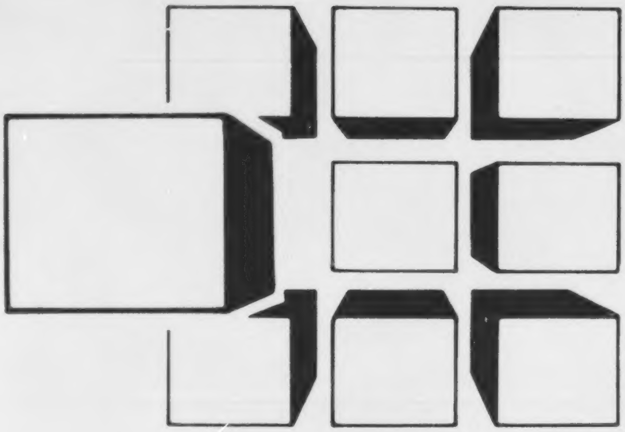
1. T
2. F
3. T
4. T
5. F
6. F
7. F
8. T

APPENDIX 1:

Role Set Diagram



1. Spouse
2. Parent
3. Grandparent
4. Relative
5. Homeowner
6. Friend
7. Volunteer
8. Citizen
9. Religious Participant
10. Employee
11. Employer
12. Neighbor
13. Club Member
14. Other



COMMUNITY RESOURCES

I. Training Goal 277

II. Cognitive Objectives 277

III. Affective Objectives 277

IV. Outline 278

V. Sample Lecture 279

VI. Annotated Bibliography 304

- A. Books 304
- B. Periodicals 304

VII. Supplementary Reading Material 307

VIII. Brochures and Pamphlets 308

IX. Audiovisual Aids 310

X. Discussion Questions 312

XI. Instructional Strategies 314

XII. Pre-and Post-Knowledge Questions/Key 316

I. TRAINING GOAL

To increase awareness of the broad range of community resources which can be utilized to benefit the older adult. To show the caseworker how the delivery of services can be better facilitated through cooperation of personnel of the various agencies.

II. COGNITIVE OBJECTIVES

- define the concept of community and list its components
- list the major service areas which address the needs of the elderly
- describe some of the types of services that are available within each of the service areas
- describe the way in which interagency cooperation can help to improve the role of the caseworker in providing services to his/her clientele
- define the concept of advocacy and discuss this notion in terms of the role of the caseworker
- identify some of the barriers to the effective utilization of community resources

III. AFFECTIVE OBJECTIVES

- become aware of the characteristics of a community which determine it's problems, needs, and social climate
- explore ways to create new resources within the community
- develop an awareness of the various types of needs often experienced by elderly clients
- understand that needs will differ from person to person
- recognize the need for being able to work with other agencies in order to develop a system of coordinated service delivery

IV. OUTLINE

A. Introduction

B. The Concept of Community

C. Identification of Community Resources

    1. Health-related resources
    2. Social Service resources
    3. Legal resources
    4. Educational resources
    5. Recreational resources

D. The Social Services Directory

E. The Volunteer as a Community Resource

F. The Role of Outreach

G. The Role of Advocacy

H. Coordination of Community Resources

I. Improving Interagency Relationships

J. References

V. SAMPLE LECTURE

A. Introduction

The caseworker must perform a variety of functions in fulfilling the role of helping person. Crucial among these tasks is the ability to serve as an effective resource broker for clients. Once the problem(s) to be worked on have been defined with the client, the caseworker needs to be able to identify the agency that can provide optimal services in that situation. Therefore, it is essential that the caseworker has a thorough knowledge of the availability and accessibility of resources in the community.

In large, complex urban areas, community resources for the elderly tend to be readily available, although probably somewhat specialized. In rural areas, on the other hand, only the most rudimentary facilities may be available. Regardless of locale, however, the caseworker may find himself in a precarious position. In the large urban area, the caseworker may have to sort through a maze of agencies to find the most appropriate service for his client. In the smaller, rural area, the problem sometimes becomes one of fitting the client to the available resource rather than fitting the resource to the client. In either case, it is the caseworker's responsibility to be familiar with the structure of the community and the available resources in order to assure that his client receives the best and most appropriate services.

B. The Concept of Community

The local department of social services is affected by all the factors and forces operating within the community. The caseworker needs to develop an understanding of "community" and the forces operating within it because only by understanding the social climate of the community can the caseworker fully comprehend the social problems and needs of the people.

Community is defined by Dunham as "a group of human beings, settled in a fairly compact and contiguous geographical area, and having significant elements of common life, as shown by manners, customs, traditions, and modes of speech." It is possible to describe the term community in a variety of ways. For example, there is the "black community," the "Greek community," the "Christian community," the "business community," and "our community." Thus, community can be described by characteristics such as race, ethnicity, religion, occupation, and locality.

Some may see their local community as a complete unit satisfying all their needs and requirements. Others might need the resources of the larger area or perhaps the county. Similarly, a local community resource may mean a great deal to one caseworker or resident of the community and not be very useful to another caseworker or resident.

It is important for the caseworker to be familiar with his "community" - the geography, population, government, housing, economics, attitudes, relationships, and resources -

in order to understand and match the needs of the client with the available resources.

C. Identification of Community Resources

The caseworker can be most helpful to the client if he possesses both the knowledge of and willingness to use the total resources of the community. Quite often, a caseworker will become especially familiar with a few select resources which have proved to be quite valuable. While it is highly beneficial for the caseworker to take advantage of such resources on behalf of his clients, it is equally important that he not become overdependent on a few resources. Knowledge of a community's total resources can help the caseworker, as well as the agency, provide a much greater scope of service.

Community resources vary greatly from locality to locality since the size and distribution of the populations to be served demand different services. Because of the breadth of possible community resources, it is impossible to list here all that might exist to serve the elderly within any given community. There are, however, some resources available in the majority of communities. These are identified and grouped in five catagories: health-related, social service, legal, educational, and recreational. While a caseworker may feel that certain resources will be of little benefit to their clientele, it is still advantageous to be aware of such resources. A broad knowledge of community resources on the part of the caseworker will serve to increase the worker's flexibility in responding to a broader range of problems and situations.

1. Health-Related Resources

The vast majority of the elderly (86%) suffer some sort of chronic condition or impairment. They are prone to experiencing more problems than their younger counterparts as evidenced by the fact that, as a group, they are seen by doctors about half as often and are hospitalized twice as frequently for almost twice as long as younger persons. In recent years the elderly spent 3-1/2 times more for health care on a per capita basis than those under 65. While older adults constitute only 10% of the population, they are responsible for 28% of all personal health care expenditures and 25% of all prescriptions for medication.

Physician's Services. The general problems associated with obtaining the services of a physician are compounded for the elderly. Not only do very few doctors specialize in the relatively new field of geriatric medicine, but frequently, doctors are reluctant to accept elderly persons as patients. This reluctance is related to the tendency of many physicians to see the medical needs of older patients as essentially maintenance-oriented. Further, transportation is frequently a problem for the frail elderly, as are the long waits encountered in doctors' offices and clinics. Thus, in order to make referrals, it is important for the caseworker to check with his county medical society for a listing of doctors and clinics that attend to the elderly, as well as those accepting Medicaid and Medicare or providing care on a sliding scale basis. Perhaps the best sources of this type of information are Visiting Nurses, Public Health Nurses, and hospital social workers working with elderly patients.

Nursing Services. Since not all patients need to be hospitalized for an illness, services are available for treatment in the home. Both the Public Health Nurses and the Visiting Nurse Association (VNA) provide multi-leveled nursing care and health maintenance in the home. Public health nurses work for tax-supported city or county health departments and services are free of charge. At the same time, the VNA is a private agency which requires direct payment on a sliding scale basis or third-party reimbursement.

Health Screening Programs. Health Screening for chronic disease helps to identify an illness before it becomes serious and when treatment has the best chance of succeeding. Health screening clinics are operated by Public Health departments, usually at senior centers or other strategically located centers and at meal sites operated by the Nutrition Program for the Elderly.

Community Mental Health Clinic (CMHC). CMHCs are usually connected with general hospitals and offer a variety of services from walk-in clinics to in-patient beds. In a few instances, CMHCs have adjusted their program to the needs of the aged and have developed a system of service-oriented mobile geriatric teams who will see patients in their own homes as well as at the center.

State Mental Hospitals. In the absence of alternatives, mental hospitals have been used to care for many aged individuals who did not need psychiatric evaluation or care. Many patients also remained in the hospital simply because they had no other place to go. Mental hospitals have been reviewing their populations and discharging many patients. These facilities are still, however, the major treatment resource for the mentally ill.

Home Health Aide Service. This service is provided to those individuals needing more than homemaking. On doctors' orders and under the supervision of a registered nurse, home health aides perform a variety of functions in tending the sick, including the planning and preparing of nutritious meals, dressing, grooming and personal hygiene.

Old Age Institution (OAI). OAI is a general term which refers to the broad scope of institutions that deal specifically with older clients. Included among OAI's are nursing homes, rest homes, and homes for the aged. The quality and extent of services provided by the OAI's cover a very wide range.

Rehabilitation Programs. Vocational and other rehabilitation programs enable older people to resume active lives after an illness or injury. Rehabilitative services such as physical and speech therapy are frequently available through home health agencies. Some of the agencies that provide rehabilitation programs are Cancer Society, Heart Association, Association for the Blind, Red Cross, Alcoholism Council, Post Stroke Association, Laryngectomee Association, Diabetes Association, Ostomy Association, and Wheels to Independence.

Home-Delivered Meals. "Meals-on-wheels" are available in most communities either in cooperation with the Nutrition Program or provided by a community group, such as a religious organization, or through a hospital. The meals are specifically for the homebound elderly during recuperative periods or when cooking is not possible.

Homemaker Service. This service helps semi-independent older people remain in their own homes by providing cleaning, shopping, laundry, and meal preparation services.

2. Social Service Resources

In addition to the health-related resources, many older people can benefit from social service resources. The community resources that are discussed in this section include the supports which are economic or social in nature.

"Good Neighbor" Activities. Various programs exist at the local level to assure the safety of the homebound elderly. Telephone reassurance and friendly visiting are examples of programs which provide the shut-in elderly with a link with the community. These programs can be operated by volunteers from senior centers or religious organizations. Some agencies are starting programs which are aided by the police, postal departments, and utility company meter readers. Police make home security inspections and give advice on how to prevent illegal entries. Postal carriers will alert the sponsoring program agency if an elderly person has not picked up his or her mail in a specified amount of time.

Counseling. Counseling is a necessary part of service delivery to the elderly. One of the main functions of a family services agency is to provide counseling services to individuals and families with emotional, marital, or personal difficulties. There are sectarian agencies, such as Catholic Charities, Jewish Family Services, and non-sectarian agencies which offer traditional counseling services.

Home Maintenance. Many elderly cannot afford or are physically unable to maintain their homes. Home repair, winterization, and home maintenance programs are operated by agencies such as County Offices for Aging (COFA), Community Action Program (CAP), religious organizations, and the Boys Club. Some agencies provide free labor and charge only for materials, while others may not charge low-income elderly, or charge on a sliding fee scale.

Nutrition Program for the Elderly. This program provides low-cost, nutritionally sound meals to those over 60 years of age and their spouses. The Nutrition Program seeks to involve those with low-incomes or those who may be socially isolated or disabled. The provision of meals in group settings is emphasized, and meal sites usually are established in churches, public housing, community centers, and other facilities where supportive services may also be available. Transportation is provided to those unable to get to the meal site unaided. The location of meal sites is available from the county or State Office for the Aging.

Adult Day Care. The concept of adult day care for the elderly is relatively new to many communities. Day care centers provide service for elderly people whose families might work during the day or who need limited treatment for physical, emotional, or social impairments. Also, day care can provide respite for families who continually care for an older person. Day care centers are operated by senior citizen clubs and centers, religious organizations, the Salvation Army, County Offices for Aging, hospitals, mental health associations and the Department of Health.

Shopping Assistance. Shopping for food and clothing can be an overwhelming problem for the aged because of mobility and transportation problems. Shopping assistance is provided through meal sites of the Nutrition Programs;

by the volunteer organization, FISH (Friends in Service Here); and by religious organizations. In addition, some large supermarket chains provide transportation services to residents of senior housing. Shopping assistance may also be one of the functions of homemaker service.

Emergency Food Programs. Many communities have established emergency food programs or a food cupboard to help those on limited incomes. Such agencies as FISH, religious organizations, the Salvation Army, and the Red Cross have sponsored food programs. Sometimes these programs are seasonal, usually at the Thanksgiving and Christmas holidays.

Housing. Older people are handicapped in the competition for adequate housing since they have less money to spend and often cannot shop around for a more advantageous change. Some agencies have a housing unit to assist the elderly in finding safer, less expensive or more accessible housing. Senior citizens' housing or rent subsidy programs, such as Section 8 of the Federal Housing and Community Development Act, may be available to expand the range of affordable housing. A County Office for Aging, Community Action Program, or Family Service Agency might provide this service. Often, there also is a need for temporary, emergency housing because of fire, damage, or eviction. The Red Cross, Salvation Army, and City Mission may have places where the client can stay until a new living situation is found.

3. Legal Resources

Several circumstances, such as impaired vision and hearing and limited education, make older people vulnerable to consumer frauds, quackery, and misleading advertising. Often, there is little a caseworker can do to protect a client. However, the caseworker should be aware of the resources available for redress. In addition to frauds, there may be other instances when legal counsel is necessary. The following types of agencies exist to help the aged person maintain his legal rights.

Legal Aid Organizations. One major problem the elderly person has in retaining the services of any attorney is expense. Free legal counsel is available to certain income-eligible elderly through the Legal Aid Society. Most large cities have a branch of this government-funded organization. Caseworkers should become familiar with the eligibility requirements so as to make appropriate referrals. Private legal aid organizations also counsel clients, but usually for a fee. Some County Offices for Aging are subcontracting with legal organizations to provide free legal advice.

County Bar Association. As a public service, many county bar associations will arrange for a half-hour appointment with a lawyer at affordable rates.

Consumer Protection. Complaints involving fraud, such as false or misleading advertising, home improvement contracts, unordered merchandise, or rental security deposits are handled by the New York State Department of Law, Office of Attorney General, Consumer Frauds and Protection Bureau. There is a branch office in every major city of New York State.

Small Claims Court. A consumer can use Small Claims Court as a medium for redress. The procedure for filing a claim is relatively simple and fees for filing are nominal. Small Claims Court permits each party in a dispute to tell his side of the disagreement, and judgment is prompt. The court only handles civil cases, and they must be within certain monetary limitations which vary depending on locality. Although the court is intended to be accessible to the average person, some persons may find appearing before a judge a fearful situation or may have difficulty in clearly relating their side of the story. Older people, in particular, may lack transportation to and from the court. Thus, the caseworker should be familiar with the forms, filing procedures, and costs involved. Local consumer affairs representatives sometimes accompany consumers to Small Claims Court. Otherwise, the elderly person might want to be accompanied by a relative, friend, or professional.

4. Educational Resources

Since most older Americans' formal schooling ended before the great achievements in public education were widely available, they have as a group a lower level of schooling. Educational resources exist within communities to help those who wish to continue their education formally or informally.

Continuing Education. Continuing education is offered by local colleges, school districts, Cooperative Extension, and senior citizen centers and clubs.

Public Library. Public libraries usually have book review discussion groups and film programs for the senior citizen. Libraries also maintain large print books and periodicals for the visually handicapped. "Talking books," or books on records or cassettes, are available for the visually handicapped, blind, and physically disabled. Books and phonograph or cassette players can be borrowed without charge from the New York State Division for the Blind and Visually Handicapped.

5. Recreational Resources

Recreation plays an important role in the lives of many older people. Recreation programs provide the opportunity for companionship, self-expression, and mental stimulation. Perhaps the chief benefit for the caseworker to consider is the reduction of social isolation. Again, resources vary among communities, but listed are some of the most widely available.

Senior Citizen Centers. Most communities have at least one center or club for senior citizens. Activities at senior citizen centers can vary widely depending upon the participants. The New York State Office for the Aging publishes a listing of clubs and centers throughout New York State.

Nutrition Programs for the Elderly. Aside from the nutritional aspects of the Nutrition Program, meal sites also provide recreational and socialization opportunities.

YMCA AND YWCA. Programs are available at the "Y" for people of all ages. Besides recreational activities, there are seminars, educational courses, community service projects, and so on.

Transportation and Escort Service. Many clubs and centers provide transportation and escort service for their members. In addition, other agencies exist which provide these services solely or as part of their program. The Salvation Army, Red Cross, FISH, and County Offices for the Aging might provide transportation as part of their service.

D. The Social Services Directory

A social service directory is a tool to which every caseworker should have access. Typically, a community's council of community services will have produced such a volume. Not all communities have a council of community services, per se, but usually there is an agency which assumes responsibility for community program development, coordination, and information and education. If an agency does not exist to perform these functions, perhaps other agencies have produced directories for their area of concern. For example, a County Office for Aging might have produced a directory delineating services for the elderly, or an association of religious organizations might have compiled a listing of churches and synagogues and the various services they provide. If this is the case, it will take some time to search out the individual directories. However, this will be time well spent, for a directory facilitates the acquisition of knowledge of community resources for the caseworker. A good place to start is the classified section of the phone book. See headings, such as social service organizations, fraternal organizations, clubs, missions, religious organizations, associations, veterans and military organizations, labor organizations, and homes-institutional. The possibility of no directory existing is scarce, but if this should be the case, perhaps agency volunteers or a community college would undertake the compilation of a directory.

The directory usually includes specific information about each social service agency, such as:

1. Who the agency is affiliated with;
2. Purpose of the agency;
3. Services provided by the agency;
4. Eligibility basis for service;
5. Contact person;
6. Process to be followed in helping a client use the resources of the particular agency.

In making referrals, the service directory can be used to help the caseworker identify appropriate services and agency providers. Too often, a client's plan is established using agencies that are "tried and true" but not necessarily the most appropriate or the most effective. The directory shows the full range of available services and should be used until the caseworker is thoroughly familiar with the service providers of his community.

Obviously, where few services exist, it is not possible to provide alternatives and choice. Yet, one goal of social services is to provide options and alternatives to respond to the unique and changing needs of the older person. The capacity to fit the service to the individual rather than following the traditional approach of fitting the individual to the service is the ideal and a major challenge to caseworkers providing services to the aging.

E. The Volunteer as a Community Resource

In order for health and welfare programs to be most effective, there should be community involvement at the grass-roots level. Interest in local problems can be a focal point in order to mobilize citizen participation. The citizen, as volunteer, can assist an agency to make some aspects of its work more effective.

Volunteers, as extensions of agency staff, can:

1. Provide supplementary service that otherwise would not be available;
2. Strengthen interagency relationships, especially

when the volunteer maintains a service interest in some aspect of a program that involves several agencies;

3. Enrich the agency's program by one's knowledge and experience;
4. Contribute to the effectiveness of the agency's public relations;
5. Help the community understand and accept the objective of a particular program; and
6. Help link the citizens of the community with the services provided by the agency.

For volunteer programs to be most effective, the administration and staff of the agency need to know which program areas and which specific tasks they want volunteers to do. Staff members must feel that volunteers add to the service of the agency. Therefore, staff should be prepared to teach, coordinate and assist volunteers in the execution of their tasks. Occasionally, staff members resist the utilization of volunteers for fear they may lose their own jobs. The administration should make it clear to staff that volunteers are an extension of agency staff and not a replacement.

In asking people to volunteer their skills and time, the agency must make clear to the volunteers how they will assist the agency. Volunteers should be provided with a job description and at least one orientation session to acquaint them with the functions, operations, and facilities of the agency. Periodic, on-going training programs are also helpful. Since volunteers are contributing their time, energy, skills, and in some cases, out-of-pocket expenses for transportation, the agency should recognize these efforts. Recognition may take the form of a formal dinner or luncheon, a certificate of merit, a pin, or plaque which shows appreciation.

Volunteers and volunteer operated programs must be evaluated to determine whether the efforts are helping to achieve the stated goal. This process should include the volunteer, staff, and clients. There are a number of ways of evaluating, from a very informal self-report to a more rigorous evaluation.

In order for a volunteer to be most effective, it is crucial that he be assigned a role in which he feels he is making a contribution and is supplementing an essential staff service. Otherwise, the volunteer may show little creativity or innovation in performing his assignment.

F. The Role of Outreach

For a myriad of reasons, small neighborhood locations of social service agencies have been abandoned for large centralized offices. This trend has created problems for the service consumer. First, physical distance from the client's home to the agency has created transportation and mobility problems. For instance:

1. It is often difficult for the older client to use public transportation;
2. Private transportation (taxi, auto) is usually beyond the means of many elderly; and

3. The older person may be hampered by a physical problem that restricts movement over long distances.

A second problem is one of social distance. Centralized services can be more difficult for the aged to use because of the client's fear in dealing with large organizations that have formalized procedures. Outreach programs can help a client to overcome these problems. Outreach is the process of searching out those in need of services and bringing the services to the client. Many agencies already operate outreach programs or periodic "campaigns," usually to the most economically disadvantaged areas of a community. Not only do these programs need expansion in the most poverty stricken areas, they also need expansion in the overall community.

G. The Role of Advocacy

Advocacy, the process of espousing a cause or pleading in another's defense, also has a place in an agency. Advocacy includes the use of all possible means from direct action to moral persuasion in order to effectively represent the needs and grievances of older people.

The purpose of advocacy is to obtain service for a client where such service is not easily available or is nonexistent. The advocate's role could be assumed by all levels of personnel in the agency. The caseworker can serve as a liason between the older person and the agency from which an attempt is being made to gain services. At a different level, the supervisor can press an agency to make changes in its policies and procedures on behalf of the older person. At yet a different level, the agency executive can be involved in advocacy for the aged by pressing another agency at the local, state, or federal level for changes in public policy on behalf of all older people in the community.

For advocacy to be meaningful, there must be accountability. It is not meaningful to challenge another agency's authority if there are no "reactions" from that agency. However, not every issue is worth a "fight." If an agency decides to advocate, they must carefully choose those issues which have the greatest possibility of bringing positive results.

There is a place for advocacy in an agency's program, but to what extent and in what form is a question for the executive to decide. Some agencies, such as Legal Aid, may have formal advocacy components in their programs. For agencies dependent on government funding, advocacy techniques such as open confrontation or demands may be questionable. These means serve to disturb relationships with other agencies in both the voluntary and non-voluntary sectors and may get no results.

H. Coordination of Community Resources

In order to maximize the extent to which community agencies are able to meet the needs of their clientele, it is important that an effective interagency coordination system be developed. Through such a system of coordination, it is possible to minimize duplication of services and overlapping of administration and, thus, provide a comprehensive service plan which is amenable to a community-wide system of support.

Frequently, coordination systems develop informally between individuals from different agencies who have become familiar with each other over a period of time. This kind of coordination is beneficial, but it also has a number of drawbacks. First, it takes a great deal of time to develop this type of relationship. Second, it is a relationship between people rather than agencies, meaning that each time there is a personnel change the coordination system must be rebuilt. Finally, one must recognize that individual workers vary in their ability to establish working relationships with other agencies.

It is felt that coordination between agencies can be effected most efficiently by establishing a formalized agreement with guidelines that provide a clear framework for the working relationship. In this way, there is an ongoing intragency commitment to the coordination system which avoids the inefficiency and haphazardness of the informal system.

I. Improving Interagency Relationships

The local department needs to be aware of gaps in community service and should attempt to understand how these gaps affect its clients. There may be times when, in order to precipitate action, the local department must assume the lead in bringing a specific social problem to the attention of other social welfare agencies and to the total community.

The local department may not always achieve results, but at least other agencies and the community will consider the problem if the local department is respected and considered part of the community network.

The present section has examined some of the ways in which community resources can be coordinated in order to provide maximum service to the client. It is important for the caseworker to bear in mind that while the responsibility for attempting to establish interagency relationships is more policy oriented and, in most cases, is beyond the scope of the average caseworker's responsibility, an understanding of how community resources can be coordinated can help the caseworker better meet the needs of his or her clientele.

In order to be part of the community network, workers in the local department must overcome certain barriers to effective community resource coordination. These include:

1. Knowledge - Basic lack of knowledge of the functions of other agencies.
2. "Agency-mindedness" - Workers sometimes feel that the needs of their agency are more important than community needs. Workers in agencies may tend to fall back on their statutory limitations and defined functions rather than trying to see what can be done about a troublesome community situation.
3. Intra-agency barriers - Frequently, there is no organized plan for the participation of staff in

working toward community resource coordination.

4. Stereotypes of other professionals and agencies - The worker in a public agency might have feelings about a worker in a private agency, and vice versa, which spring from differences in setting, practice, and training. There is a need to understand and accept the differences among workers, just as differences among clients or other people are accepted.

5. Ineffective machinery and structure for community coordination - There may not be a council of social agencies or a community welfare council in the area, or there may be more than one agency which feels it has planning and coordinating responsibility for the entire community. In either case, there is no one organization with a neutral community point of view that can bring separate agencies together on mutual problems.

The local social services department through its caseworkers and other level employees can do many things to improve interagency relationships. Among these are:

1. Maintain sound communication lines with other community agencies;
2. Orient new workers and volunteers to the community and include material on the community in staff development;
3. Make visits to other agencies to meet staff who may

be only a "voice on the phone," and tour the agency;

4. Invite staff from other agencies to make field trips to D.S.S.;
5. Involve staff from other agencies in in-service training/orientation programs;
6. Make a conscious effort to see your agency as other agencies and the community see it;
7. Work with other agencies in common service projects.
8. Participate in total community planning and coordination;
9. Understand emerging social needs brought about by community changes and be responsive to the change.

J. References

Binstock, R., & Shanas, E. *Handbook of aging and the social sciences*. New York: Van Nostrand Reinhold Co., 1976.

Butler, R., & Lewis, M. *Aging and mental health*. St. Louis: C. V. Mosby Co., 1973.

Dunham, A. *Community welfare organization*. New York: Crowell, 1958.

Hungate, J.I. *A guide for training local public welfare administrators*. U.S. Department of Health, Education and Welfare, Welfare Administration, Bureau of Family Services, Division of Technical Training, 1964.

Morris, R. Aging and the field of social work. In M.W. Riley, J.W. Riley, Jr., & M.E. Johnson (Eds.), *Aging and society* (Vol. 2). New York: Russell Sage Foundation, 1969.

Pflanczer, S.I. *Community resources and protective service work in child welfare*. Prepared for a training program in child abuse and neglect, School of Social Welfare, The University at Albany, 1975.

Role of Advocacy (working draft). Prepared by Institute of Interdisciplinary Studies for Administration on Aging, Office of Human Development, 1971.

Szulgit, J. Volunteer programs. In S. Sherman, L. Winegar, & R. Famighetti (Eds.), *Contemporary issues in services to the older adult: A basic reader*. Albany, New York: Institute of Gerontology, School of Social Welfare, The University at Albany, 1977.

Tiven, M.B. *Older Americans: Special handling requested*. (Prepared under HUD Contract H-1294 by The National Council on the Aging). Washington, D.C.: U.S. Government Printing Office, 1971.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Lawton, M.P., Newcomer, R.J., & Byerts, T.O. (Eds.). *Community planning for an aging society: Designing services and facilities*. Stroudsburg, Pa.: Dowden, Hutchinson & Ross, 1976.

This anthology provides an introduction to the links between good planning, delivery of social services, and the quality of the built environment. The book is divided into three units. The first unit examines the aged population in urban life and also looks at ethnicity. The second unit examines community planning and policy decisions as they affect older people. The third unit explores the community services available and looks at neighborhoods as service systems.

Wieboldt Foundation Project. *Community services for older people: The Chicago plan*. New York: Wilcox and Follett Co., 1952.

This research report was conducted during the years 1947-51 by the Community Project for the Aged of the Welfare Council of Metropolitan Chicago. Although some of the material is dated, especially demographic profiles, it has some useful chapters on community education, home services, recreation and casework.

B. Periodicals

The Ad Hoc Committee on Advocacy. The social worker as advocate: Champion of social victims. *Social Work*, 1969, *14*(2), 16-22.

The obligation of social workers to become advocates flows directly from the social worker's Code of Ethics. This obligation and the role of NASW in advocacy are discussed.

Cohen, R.G. Outreach and advocacy in the treatment of the aged. *Social Casework*, 1974, *55*(5), 271-77.

In this article, the writer describes several approaches used by Jewish Family Services of Philadelphia to reach out to the elderly. The article describes three projects which demonstrate the value of maintaining older persons in the mainstream of community life.

Herz, K.G. Community resources and services to help independent living. *Gerontologist*, 1971, *11*(1), 59-66.

This article shows how noninstitutional services can prevent or postpone premature institutionalization of older people. It explores some of these service networks: homemaker and home health aide, volunteers and the neighborhood information center.

Heyman, D.K., & Polansky, G.H. Social casework and community services for the aged. In E. W. Busse & E. Pfeiffer (Eds.), *Behavior and adaptation in late life* (2nd Ed.). Boston: Little, Brown and Co., 1977.

This article describes the various community services available to the aged: information and referral, outreach, retirement planning, meals-on-wheels, and homemaker services. It also outlines the worker's role in providing these services.

Leanse, J. The senior center, individuals, and the community. In R. Kalish (Ed.), *The later years - social applications of gerontology*. Monterey, Ca.: Brooks/Cole Publishing Co., 1977.

This article delineates the historical development of senior centers, describes the need for centers today, and discusses the philosophy of the senior center movement.

Litwak, E. An approach to linkage in "grass roots" community organization. In F. Cox, J. L. Erlisch, J. Rothman, & J. E. Trapmen (Eds.), *Strategies of community organization*. Itasca, Ill.: Peacock Publishers, 1974.

This paper outlines a theory of relationships between professionals and community groups and how these linkages might be used to guide social work practice. It formulates a "grass roots" approach by utilizing family, neighbors, and informal groups to work with professionals to provide services.

Sainer, J.S. The community cares: Older volunteers. Social Policy, 1976, 7, 73-76.

This article examines what benefits volunteerism offers to the aging and their communities. It explores volunteerism by looking at two organizations, SERVE and RSVP.

VII. SUPPLEMENTARY READING MATERIAL

Buckley, M. *The aged are people, too - about William Posner and social work with the old.* Port Washington, New York: Kennikat Press, 1972.

Feldman, A.G., & Feldman, F.L. Community strategies and the aged. In A.N. Schwartz & I.N. Mensh (Eds.), *Professional obligations and approaches to the aged.* Springfield, Illinois: Thomas, 1974.

Matteson, S. Spirit of '76 - Independence in old age. *Trial*, 1974, *10*(2), 20-22.

Morris, R., & Randall, O.A. Planning and organization of community services for the elderly. *Social Work*, 1965, 96-102.

Payne, B.P. The older volunteer: Social role continuity and development. *Gerontologist*, 1977, *17*(4), 355-61.

Rosenblatt, C. Isolation and resistance in the elderly: A community mental health problem. *Journal of Psychiatric Nursing and Mental Health Services*, July-August, 1972, *10*(4), 22-25.

Sherman, S.R. Provision of on-site services in retirement housing. *International Journal of Aging and Human Development*, 1975, *6*(3), 229-247.

Simpson, D.F., & Farrow, F.G. Three community systems of services to the aging. *Social Casework*, 1973, *54*(2), 96-104.

VIII. BROCHURES AND PAMPHLETS

Homemaker Health Aide Service: Training Manual

This booklet describes the goals of homemaker service, the role of the homemaker, and types of services provided. A special chapter is devoted to the training of homemakers for work with the elderly. Nutrition and home management are also included.

Available from: U.S. Department of H.E.W.
Office of Human Development
Administration on Aging
Washington, D.C. 20201

Let's End Isolation

This booklet outlines the needs of the isolated elderly and discusses the means to meet these needs. Programs such as transportation, Senior Centers, telephone reassurance, friendly visiting, in-home services, and outreach programs are dealt with.

Available from: U.S. Department of H.E.W.
Office of Human Development
Washington, D.C. 20201

Publication # (OHD) 75-20129

Ring-A-Day Telephone Reassurance Service

This brochure describes what the service is, who qualifies, and how to start such a service.

Available from: Department of Senior Affairs
County of Nassau
Barbara A. Kennedy, Coordinator
Ring-A-Day Reassurance Service
1 Old Country Road
Carle Place, New York 11514

To Find the Way: To Opportunities and Services for Older Americans

This booklet provides information on health care, money management, housing, nutrition, transportation, as well as senior power. Easy to read, the booklet also provides additional sources of information.

Available from: Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20401

DHEW Publication # (OHD) 75-20807
Price: $.60

What is a Multi-Purpose Senior Center?

This pamphlet describes the purposes of a multi-purpose senior center - its services to the individual and to the community. It also describes who may sponsor such a facility and the responsibilities involved.

Available from: National Institute of Senior Centers
The National Council of the Aging, Inc.
1828 L Street, N.W.
Washington, D.C. 20036

IX. AUDIOVISUAL AIDS

A MATTER OF INDIFFERENCE

16 mm film/Black & White
45 minutes, 1976
Available from: Phoenix Films, Inc.
Rental: $ 50.00
Purchase: 400.00

Through a provocative interview with Maggie Kuhn, founder of the Gray Panther movement, this film explores the obligation of old people to live their lives to the fullest. Ms. Kuhn speaks to the issues of identity, loss of social status, and the family in relation to older people's involvement in social action.

THE LATER YEARS OF THE WOODLEYS

16 mm film/Black & White
30 minutes, 1971
Available from: New York State Department of Social Services
No fee: on request

This film illustrates the cause-effect relationship of aging and ill health. It discusses the effectiveness of appropriate medical care and how community services of all kinds are needed to care for the elderly. Continuity of contact as a factor in establishing a helpful relationship is also brought out.

TELL ME WHERE TO TURN

16 mm film/Black & White
30 minutes, 1975
Available from: New York State Office for the Aging

This film is designed to show how Information and Referral Services help to remove barriers between people who need help and those whose job it is to give help.

HOMEFIRES

16 mm film/Black & White
28 minutes, 1976
Available from: North Texas State University Gerontological Film Collection

This film shows the salient aspects of the Homemaker-

Home Health Aide Service as a form of assistance to families or individuals who cannot maintain living and household routines during a time of stress or crisis. In three case histories, the film shows the relationship between health or welfare agency staff, as well as the duties and responsibilities of the Homemaker-Home Health Aide.

X. DISCUSSION QUESTIONS

1. Community has been defined as, "A group of human beings, settled in a fairly compact and contiguous geographical area, and having significant elements of common life, as shown by manners, customs, traditions, and modes of speech."

    A. What are some of the characteristics that differentiate your community from others?

    B. Which of these characteristics are important in determining your community's social climate and needs?

    C. How do these characteristics affect the delivery of social services?

2. "Community Resources vary greatly from locality to locality."

    A. How would you rate the availability of each of the following types of services in your community?

        1. Health Resources
        2. Social Services Resources
        3. Legal Resources
        4. Recreational Resources
        5. Educational Resources

    B. In which areas do you see a need for new or "better" resources? Why?

    C. What kinds of Community Resources would you like to see developed over the next 25 years?

3. The use of volunteers as a supplement to Department of Social Services staff provides community involvement at the grass roots level and enables the agency to work more effectively.

    A. Based upon your experience, how do you react to this statement? Why?

    B. Do you have any ideas on how volunteers could be utilized more effectively?

4. "In order for a volunteer effort to be successful, the volunteer must feel that she is making a significant contribution to the agency and that her efforts are being recognized and appreciated."

A. What can the caseworker do to encourage and reward the volunteer?

5. Caseworkers are frequently asked to assume the role of client advocate, a position that occasionally causes conflict between the needs of the client, the caseworker's responsibility to his agency, and the policies of other community agencies.

   A. Do you believe the caseworker has a responsibility to act as a client advocate? Why? Why not?

   B. Do you feel that it is possible for a caseworker to "fight" against his own agency in behalf of a client? What might be possible penalties? Rewards?

   C. What are some of the factors that encourage or restrain effective client advocacy in your community?

6. In order to make available to the client the most comprehensive service plan possible, there must exist a formal system of coordination between agencies.

   A. How do you react to this statement? Why?

   B. What kinds of interagency coordination exist in your county?

   C. In which areas do you see a need for more or better coordination? Why?

   D. What conditions exist in your community that would affect interagency linkages?

XI. INSTRUCTIONAL STRATEGIES

1. Objective: To create an awareness of and generate interest in available resources in the community.

Method:

a. Invite guest speakers from community agencies, professional, religious, or civic organizations, individually or as a panel to discuss their agency's purpose, role in the community, how their services are coordinated with other agencies, etc.

b. Arrange for field trips to various agencies. Participants should prepare questions on the agency prior to the trip.

c. Invite consumers of community resources to discuss how they perceive the delivered service.

d. Secure copies of community's social service directory, if available, for distribution. If unavailable, group might wish to elect a task force to compile such a directory.

2. Objective: To sensitize caseworkers to the role of volunteers in a community agency.

Method:

a. Invite a volunteer coordinator to discuss how to effectively recruit, utilize and keep volunteers. Volunteers could also be invited to discuss how they see their role in the agency.

b. Break into small groups. Each group is assigned a topic area to brainstorm. Groups write their ideas on newsprint, and at end of session, a representative from each group reports to large group on:

   1. Where and how to recruit volunteers;
   2. How to motivate volunteers;
   3. How to assess need for volunteers;
   4. How to interview and select volunteers;
   5. How to train volunteers;
   6. How to supervise volunteers;
   7. How to evaluate volunteers.

3. Objective: To educate to the role of outreach in a community agency.

   Method: Invite an outreach worker from an agency or other source to discuss what outreach is, how to assess target areas, how to conduct a successful outreach campaign, etc.

4. Objective: To sensitize to the function of advocacy.

   Method: Create a role-play situation with individuals representing a client, client advocate, and service agency worker.

5. Objective: To create awareness of community resource coordination.

   Method: Invite representatives from other agencies and arrange small groups to discuss:

   a. What goals do we want to pursue in community resource coordination?

   b. What are the needs of our community?

   c. What resources exist to meet the needs? What is lacking?

   d. Are services flexible enough to meet unmet needs?

   e. To what extent is there duplication of services?

   f. Where do we go from here?

XII. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F Visiting Nurse Services are generally capable of providing nursing care, as well as, physical, speech and occupational therapy.

2. T or F The Nutrition Program for the Elderly provides low-cost, nutritionally sound meals to those 60 years of age or older and their spouses.

3. T or F Representation by a lawyer is necessary in a Small Claims Court procedure.

4. T or F In order for agencies to best coordinate their services, there should be a formalized agreement or understanding about conditions under which one agency's clients may use another's resources.

5. T or F Volunteers can help the community understand and accept the objectives of a particular program.

6. T or F For a volunteer to be most effective, he must be assigned a role in which he is making a contribution and is supplementing an essential staff service.

7. T or F Telephone Reassurance and Friendly Visiting are two programs which provide the shut-in elderly with a link to the community.

8. T or F The caseworker can serve as legal counsel to the older client.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. T
2. T
3. F
4. T
5. T
6. T
7. T
8. F

ALTERNATIVES TO INSTITUTIONALIZATION

I. Training Goal 321

II. Cognitive Objectives 321

III. Affective Objectives 321

IV. Outline 322

V. Sample Lecture 323

VI. Annotated Bibliography 335

- A. Books 335
- B. Periodicals 336

VII. Supplementary Reading Material 340

VIII. Audiovisual Aids 341

IX. Discussion Questions 343

X. Instructional Strategies 344

XI. Pre-and Post-Knowledge Questions/Key 346

I. TRAINING GOAL

To provide information about some of the options to institutionalization which can be utilized with older adult clients. To explore the concept of foster care for adults.

II. COGNITIVE OBJECTIVES

- describe several options to institutionalization
- differentiate between in-home services and congregate living
- describe the major goal of sheltered housing
- list some sheltered housing options
- define some of the components of foster care for adults
- describe advantages and shortcomings of foster care for adults and delineate how the potential shortcomings can be minimized

III. AFFECTIVE OBJECTIVES

- understand the importance of options to the older person who otherwise would require institutionalization
- develop an awareness of positive and negative aspects of each category of options, as perceived by the older person
- realize that there may exist several options to institutionalization for each individual

IV. OUTLINE

A. Introduction

B. The Range of Options

1. In-home services
2. Congregate home-based care
3. Sheltered living arrangements

C. Foster Care for Adults

1. Advantages of foster care for adults
2. Potential shortcomings of foster care for adults
3. Foster care for adults in New York State: Rules and regulations

D. References

V. SAMPLE LECTURE

A. Introduction

One of the most prevalent myths associated with growing old in American society is that most elderly persons are institutionalized. In reality, although only four to five percent of all older persons reside in an institutional setting, it has been estimated that 25% of all persons are institutionalized at some time in their lives. Of this group of people, the General Accounting Office has noted that "about 25% of the patient population are treated in facilities which are excessive to their needs."

Further, a recent publication of the Department of Health, Education, and Welfare (1975) suggests that a great number of institutionalized persons could have remained in the community had appropriate services and environments been available. As one response to these charges, policy makers have been focusing attention on alternatives to institutionalization. The present discussion will examine some of these alternatives and their implications toward improving the quality of the lives of many older persons.

Before looking at some of the alternatives to institutionalization, it is important to consider the possibility that the word "alternatives," as used here, may not be entirely appropriate since "alternative" implies a dichotomy where one of the two choices is "bad." Obviously, however, there are some individuals for whom institutionalization is the most practical and beneficial choice. Brody feels that perhaps the term "options" would be more appropriate since this term refers to the right of the person to choose from a realm of possibilities. Throughout the present discussion, despite the different definitions, the two terms will be used more or less interchangeably.

B. The Range of Options

The heterogeneity of the elderly population necessitates the provision of a broad range of living environments for older persons. While about 95 percent of all older adults reside in the community, there are vast differences in the housing needs of this group. For those elderly persons who are in relatively good health and have a rather high degree of financial independence, there may be little need for housing-related services. However, as health and financial independence begin to diminish, the need for such services tends to become increasingly important.

There are three major categories of alternatives to institutionalization. One group includes those options which bring services to the person in his or her home. This group of options can be referred to as "in-home services." The second category consists of options which are provided to the elderly person as part of a congregate housing arrangement. This category might appropriately be labeled "congregate home-based care." The third category consists of semi-institutional alternatives, referred to here as "sheltered living arrangements."

It is important to bear in mind that while a person's degree of independence is frequently a reflection of his or her living arrangement, such is not always the case. Another factor which has a bearing on the extent of one's independence is the level of care that is required. For instance, a person who lives at home and requires only minimal home care would be considered more independent than a person who is almost entirely dependent on in-home services care. Similarly, a person who lives in an adult foster home but requires little care can be considered more independent than the home-bound person who requires extensive home services.

1. In-home services

The primary objective of this type of care is to keep the older person functioning in his or her own home for as long as possible. This category of options is based on the belief that the quality of life is greater in the familiar surroundings of one's own home as opposed to the ambiguity which often accompanies life in an institution. Examples of in-home services include homemaker services, meals-on-wheels, shopping assistance, and home health care programs.

It is important when providing home care services to the elderly to keep in mind that the problems of most clients will tend to be multi-faceted. The majority of clients, therefore, will be in need of a combination of two or more services. For instance, the condition of a person who receives medical treatment for malnutrition will improve but will not be sustained unless the treatment is supplemented with an adequate diet on an ongoing basis.

A pilot program which attempts to meet the multiple needs of home-bound older persons in New York City has been described by Brickner and his associates. In this program, teams of physicians, nurses, and social workers combine skills to provide "the home delivery of a full range of health-related services." The physician provides medical care to the client and, when necessary, makes arrangements for hospitalization. The registered nurse, in addition to providing nursing care, evaluates referrals in order to determine how staff can best be utilized within each given case. The social worker helps the client "deal effectively with the complex bureaucracy of the city" in order to receive those benefits for which the client is eligible. The authors estimate that without this program, 85% of those who were able to remain at home would have needed to be institutionalized at some point during the first two years of the program.

When providing home care services to the elderly, it is essential that the caseworker be aware of resources that are available in the community. Without this knowledge, the caseworker cannot be of maximum service to his or her clientele.

2. Congregate home-based care

In congregate housing, an attempt is made to provide a variety of easily accessible services in an atmosphere which encourages independent living. This group of options is perhaps best exemplified by senior citizen apartment housing. Many of the same types of services that are provided through in-home services can be made available at the housing complex. For instance, meals can be provided in a common eating area, nursing personnel can be provided on a regular basis, and in many cases, shops can be located on the premises. All in all, congregate housing tends to facilitate maximum delivery of services since the geographical distribution of clients is not an issue of great concern.

An additional potential benefit of congregate housing over traditional housing is the opportunity for greater interpersonal interaction. One of the major problems experienced by many older persons who live in their own homes is loneliness and isolation. The close contact which is inevitable in the congregate setting can help to minimize this loneliness.

3. Sheltered living arrangements

The final category of options consists of what Kahana and Coe refer to as "semi-institutional alternatives." The goal of the sheltered living arrangement is to keep in the community as long as possible those persons needing special care on a regular basis.

Sheltered housing has been used to reintegrate institutionalized psychiatric patients into the community. Although these various forms of "new" environment are used for other groups - such as children, the mentally ill, and the handicapped - with the exception of boarding homes, these options have not yet been used to date to any large extent for the elderly. In recent years, there has been an increasing tendency to provide sheltered housing for those older persons who would otherwise be placed in the geriatric unit of state mental institutions.

Included among this category of options are settings such as day hospitals, hostels, halfway houses, and boarding homes. Day hospitals are an outpatient option where the patient receives intensive treatment during the day but lives in the community, either alone or with friends. Also referred to as day care centers, these programs allow the patient to receive regular medical and psychiatric care while maintaining a relative degree of independence within the community. As of the present time, day hospitals have been successful in England, Australia, and Canada. In the U.S., this option to institutionalization has not been utilized to any great extent.

Supervised living facilities, popularly referred to as "hostels," are an alternative for those persons who are generally mentally disabled, but require only a minimal amount of care. Many of the residents of a hostel hold jobs in the community or in sheltered workshops. Most hostels accommodate between five and 25 residents.

Halfway houses, for the most part, are a traditional form of residence for the institutionalized person who is returning to the community. Traditionally, this type of alternative has been used with residents of psychiatric institutions who are about to be reintegrated into the community. When dealing with an elderly clientele, however, the halfway house serves as a form of semi-independent housing, as opposed to the transitional setting it provides for post-psychiatric patients.

Another option in sheltered living is Residential Care Homes for Adults. Sometimes referred to as "adult care homes," these facilities are under the jurisdiction of the New York State Department of Social Services. The most widely known type of adult care home is the Private Proprietary Homes for Adults (PPHAs) which provide, in addition to lodging and board, personal care to the resident. Such homes can be private, profit-making ventures, or they can be facilities operated by religious or non-profit organizations.

Perhaps one of the most innovative sheltered housing arrangements for older adults is the concept of foster care for adults. Adult foster care is a relatively unexplored alternative which has not yet had a great deal of empirical research. It does, however, appear to be a viable option for the elderly, and thus, the remainder of this discussion will focus on this alternative to institutionalization.

C. Foster Care for Adults

The concept of foster care for adults is based on the rationale which is used in the more widely known foster care program for children, except that the former is modified to meet the special needs of the adult. According to Title XX Statutes, the purpose of adult foster care is to provide "the best opportunities for enjoyment of normal family and community life through help with personal problems and with problems of adjusting to new living situations" and to provide "assistance in obtaining other necessary supportive services." According to Kahana and Coe, the rationale for this type of alternative is based on the view of Kluckhohn that the family is the optimal social unit for providing care.

In the foster home setting, the person who is responsible for the operation of the home is the foster home provider. The operator is also frequently referred to as the "provider." A profile of operators in New York State by Sherman and Newman found that most are women at least 40 years of age, and about half of whom live with their spouses.

Those persons who receive care in an adult foster home are referred to as the clients or residents. Initially, this alternative to institutionalization was used primarily with adult clients who had been released from a mental institution. In recent years, however, there has been an increasing tendency to utilize this option with older adults in lieu of placement in one of the wide range of old age institutions.

Who is eligible for adult foster care? Some of the criteria which have been used to determine eligibility for the program in New York include, but are not limited to, the following:

- The candidate is not in need of nursing care as certified by medical evaluation.
- The candidate must be able to care for his or her own personal needs, such as bathing and dressing, with minimal assistance when necessary.
- The candidate must be alert enough to take part in the planning for his move into the foster home.

1. Advantages of foster care for adults

Obviously, the overriding advantage of foster care for the older adult is the opportunity for the person to remain within the community and forestall institutionalization for as long as possible. However, there are other potential benefits with this option to institutionalization.

One advantage is that the foster home setting provides the potential for family-type interaction. The operator and her family can serve as a surrogate family for the client. In order for this type of familism to occur, it is essential that the client be fully integrated into the family setting, both physically and psychologically.

Another possible advantage of foster care for adults is the opportunity for mutual satisfaction for both the resident and the caretaker. As mentioned earlier, this setting obviates the need for institutionalization. In most cases, the avoidance of the institution is highly satisfying to the resident. At the same time, the provider can feel a great deal of intrinsic satisfaction in knowing that she is fulfilling a meaningful role to other persons.

2. Potential shortcomings of foster care for adults

For the most part, adult foster care appears to be a viable option for older adults. Still, the concept is susceptible to certain shortcomings. However, with adequate foresight and preparation, most of these pitfalls can be overcome.

One potential problematic area is the reaction of the residents of the community and, more specifically, neighbors to the presence of such homes in the community. The stigma which is frequently attached to mental patients and, to a lesser extent, older persons can be detrimental to the acceptance of foster homes by the community. However, Sherman and Newman, in their study of foster care for adults in the State of New York, point out that only one out of 100 operators reported disapproval of neighbors toward the program.

Another shortcoming of adult foster care programs as of the present time has been a lack of adequate training for operators. This lack of training has led to much inconsistancy across the operation of foster homes. At the present time, in response to the need for training of operators, programs are being developed to fulfill this need.

3. Foster care for adults in New York State: Rules and regulations

The New York State Department of Social Services is in the process of revising its regulations on adult foster care. Therefore, these regulations have not been covered in the present discussion. Information about these policies and procedures can be obtained from the Division of Adult Residential Care.

D. References

Brody, E. M. Seeking appropriate options for living arrangements. In E. Pfeiffer (Ed.), Alternatives to institutional care for older Americans: Practice and planning. Durham, N.C.: Center for the Study of Aging and Human Development, Duke University, 1973.

Kahana, E., & Coe, R. Alternatives in long-term care. In S. Sherwood (Ed.), Long-term care. New York: Spectrum Publications, 1975.

Sherman, S. R., & Newman, E. S. Options in intermediate sheltered housing for the elderly. Albany: Institute of Gerontology, School of Social Welfare, The University at Albany, 1976.

Department of Health, Education, and Welfare, Division of Long-Term Care. A promise kept: A progress report. Rockville, Md., 1976.

Kluckhohn, C. Variation in the human family. In Community Service Society of New York. The family in a democratic society: Anniversary papers of the Community Service Society of New York. New York: Columbia University Press, 1949.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Brody, E. M. Long-term care of older people: A practical guide. New York: Human Sciences Press, 1977.

This book addresses itself to the long-term care of older people living either in the community or residing in institutions of various types, including nursing homes and homes for the aged. Summarizing treatment programs, research findings, and their clinical implications for practice, this book is a useful tool for social workers in dealing with and understanding the older client. The book includes illustrative case materials, forms, and procedures which facilitate the process of institutionalization. There are chapters on the background of the populations of long-term care facilities, issues of care and treatment, and a detailed "how-to-do-it" section.

Sherwood, S. (Ed.). Long term care: A handbook for researchers, planners, and providers. New York: Spectrum Publications, 1975.

This book provides a summary of what is known, what has been done, and significant research findings across a wide array of topics and research interests relevant to long-term care. The literature and research pertaining to various dimensions of long-term care are reviewed and analyzed, particularly in terms of implications for future research.

Pfeiffer, E. (Ed.). Alternatives to institutional care for older Americans: Practice and planning. (Proceedings of the conference, "Alternatives to Institutional Care for Older Americans: Practice and Planning." Held at Duke University, June 1-3, 1972). Durham, N.C.: Duke University, 1973.

This conference report outlines the concept of alternatives to institutional care and examines the issue in relation to who wants alternatives to institutional care and for what reasons. These include the government, the families of older persons, the providers of health care, and the impaired older person.

B. Periodicals

Bell, W. G. Community care for the elderly: An alternative to institutionalization. Gerontologist, 1973, 13(3), 349-354.

This article examines the concept of community-based care for impaired older people by examining two basic policy issues: economics and personal preference. The author presents an outline for a community-based program which would consist of five components: health maintenance, home help, mobile meals, transportation service, and counseling, crisis intervention and advocacy.

Brody, E. Seeking appropriate options for living arrangements. In Alternatives to institutional care for older Americans: Practice and planning. Durham, N.C.: Duke University, 1973.

This article demonstrates that institutional care per se is not bad, or that community living per se is not good. Rather, the quality of each and the situation of the individual needs to be assessed when establishing a treatment plan for a client.

Brody also indicates that living arrangements involve several components, including the physical structure, the wider physical environment (e.g., neighborhood), the social or interpersonal environment, and the service environment. This has implications for social work on direct practice and management and research levels, as well as for other professions, such as architects, medical personnel, and so on.

Feuske, V., & Roecker, M. Finding foster homes for adults. Public Welfare, 1971, 29(4), 404-409.

This article explores the use and feasibility of foster family homes for adults who need a place to receive care in order to postpone or prevent institutionalization. It describes the process of recruitment of foster homes, the screening procedure, and the maintenance of such homes by looking at one project in the State of Washington.

Gustafson, E. Day care for the elderly. Gerontologist, 1974, 14(1), 46-49.

This article describes how the development of day care for older adults will provide a new option to fill the current gap between independent living and total institutionalization. The author describes a few pioneering efforts in the provision of such services and outlines some of the current financial and attitudinal problems in establishing these services.

Kistin, H., & Morris, R. Alternatives to institutional care for the elderly and disabled. Gerontologist, 1972, 12(1), 139-142.

Many institutionalized elderly persons, according to the authors, could remain in their homes with the aid of workers to do household chores, shopping, etc. A demonstration project in Massachusetts is described to demonstrate the feasibility of a home care program.

Kosberg, J. I. The nursing home: A social work paradox. Social Work, 1973, 18, 104-110.

Kosberg describes the role of social workers in nursing homes and lists some reasons for the lack of social work services in many institutions.

Kosberg, J. I. Differences in proprietary institutions caring for affluent and nonaffluent elderly. Gerontologist, 1973, 13, 299-304.

This article delineates that institutionalization is often society's answer to the question of how to care for the nonaffluent elderly. The article indicates that there are differences between institutions caring for affluent vs. nonaffluent residents in four major areas: quality of care, quantity of resources, physical factors, and staff treatment and attitudes.

Although the author does not deal directly with alternatives to institutionalization, it does point out the need for consideration of such alternatives and/or improvements in existing modes of service provision.

Metha, N. H., & Mack, C. M. Day care services: An alternative to institutional care. Journal of the American Geriatrics Society, 1975, 23(6), 280-283.

This article defines three levels of health care for aging persons in our society: at home under guidance of professional health personnel, periodic provision by health professionals, and 24-hour care provided by health institutions. It also expands upon day care as an option at the second level. A short history of day care is provided and its legal definition under New York State Law presented. The day care program at St. Camillus Nursing Home in Syracuse, New York, is described, which gives an indication of what services can be provided and how they are financed.

Newman, E. S., & Sherman, S. R. A survey of caretakers in adult foster homes. Gerontologist, 1977, 17(5), 436-439.

This paper investigates one alternative to institutionalization, foster home or family-care placement, as it is utilized in New York State. Three distinct family care programs for the elderly are examined in terms of a framework which includes the individual, the family, and the community.

Sharkey, H. B. Sustaining the aged in the community. Social Work, 1962, I, 18-22.

In this article, Sharkey presents a description of aged clients and their family situations. He also enumerates several types of contacts with the clients to sustain them in the community. These include intervention in the family pattern of living, plus the use of a part-time homemaker; use of groups (both treatment and quasi-social); family life education programs; and regular casework services to deal with medical, social, financial and psychological problems.

Sherman, S. R., & Newman, E. S. Foster family care for the elderly in New York State. Gerontologist, 1977, 17(6), 513-520.

Current literature on the topic of foster care for adults is discussed in this article. Special emphasis is placed on foster care programs in the state of New York. Also, the article contains an analysis of some of the components of adult foster care.

Wohlford, M. Adult foster care - a unique answer.
Public Welfare, 1968, 26(3), 223-226.

The article describes a foster care program operating in Wisconsin. The article discusses the clients served, as well as the sponsors and their homes. There is also some indication of the social worker's role in the program; i.e., intervention in adjusting to the home and in matching "guests" with "sponsors").

VII. SUPPLEMENTARY READING MATERIAL

Bronson, E. P. An experiment in intermediate housing facilities for the elderly. *Gerontologist*, 1972, *12*(1), 22-26.

Jackson, J. Really, there are existing alternatives to institutionalization for aged blacks. In E. Pfeiffer, (Ed.), *Alternatives to institutional care for older Americans: Practice and planning*. Durham: Duke University Press, 1973.

Lieberman, M. A. Institutionalization of the aged: Effects on behavior. *Journal of Gerontology*, 1969, *24*, 330-342.

Shore, H. What's new about alternatives. *Gerontologist*, 1974, *14*(1), 6-11.

Subcommittee on Long-Term Care of the Special Committee on Aging, U. S. Senate. *Nursing home care in the United States: Failure in public policy, introductory report*. Washington, D.C.: Government Printing Office, 1976.

Trager, B. *Home health services in the United States*. (A report to the Special Committee on Aging, U. S. Senate). Washington, D.C.: Government Printing Office, 1972.

Waldman, A. Non-institutional living arrangements for the aged - fact or fiction. In *Selected Papers, 5th Annual conference of State executives on Aging*. Washington, D.C.: Department of Health, Education and Welfare, 1965.

Yawney, B. A., & Slouer, D. L. Relocation of the elderly. *Social Work*, 1973, *18*, 86-95.

VIII. AUDIOVISUAL AIDS

WHEN PARENTS GROW OLD

16mm film/Color
16 minutes, 1976
Available from: Learning Corporation of America
Rental fee on request

What is it like to be a proud, self-made 80-year old man who is just recently widowed and is unable due to poor health to remain in his own home? The ailing father is unwilling to move into any kind of housing alternative or to hire a homemaker or home-health aide. He is convinced that he can care for himself, but his family is reluctant to let him live alone. This film, edited from the feature film, I Never Sang for My Father, is a good source to stimulate discussion on living arrangements, as well as family relationships.

BEYOND SHELTER: IDEAS ON HOUSING FOR THE ELDERLY

16mm film or video cassette/Color
25 minutes, 1975
Available from: Transit Media
Rental : $ 25.00
Purchase: 375.00
Videocassette $250.00

This film describes a variety of alternatives to sterile institutions by examining the housing problems of Denmark's elderly.

NOBODY EVER DIED OF OLD AGE

16mm film/Color
65 minutes, 1975
Available from: Films Incorporated or Adult Services,
Continuing Education Project
Rental : $ 45.00
Purchase: 650.00
No rental fee in New York State

This film dramatizes the lives of a series of resourcefully independent citizens in their later years who are struggling to survive with dignity. Although a variety of life-styles are depicted, all face institutionalization as their ultimate end. The film suggests that group living arrangements can help the old. For one, the needs of the group are met by healthier members. The film raises the issue of institutional living as the only resource vs. the well-being of its recipient.

WEEKEND

16mm film/Color
12 minutes, 1973
Available from: Mass Media Ministries or
Continuing Education Project
Rental : $ 15.00
Purchase: 150.00
No rental fee in New York State

Without dialogue of any kind, we watch a sad ritual take place as the nuclear family disposes of what it can no longer contain - the aged parent. In a highly symbolic display, the family conducts itself on a picnic in the country. Nothing unnatural or unusual appears to be happening, until gradually it becomes apparent that for the elderly man, it is a one-way trip. This film will probably provoke resentments as well as sentiment, so it serves well to stimulate discussion.

IX. DISCUSSION QUESTIONS

1. Many institutionalized older persons could be maintained in the community with the presence of adequate options to institutionalization.

   A. React to this statement. Do you agree or disagree?

   B. Is this financially feasible, given the realities of present funding mechanisms?

2. Options to institutionalization have been divided into three major categories in this module.

   A. Discuss each of these categories in terms of relative strengths and weaknesses.

   B. Which category is most beneficial for the person who needs minimal care? For the person who needs extensive care?

3. Rehabilitation should be stressed as a major goal of noninstitutional living arrangements.

   A. Why or why not?

   B. Under what conditions?

4. Foster care for adults is a living arrangement which has recently begun to receive much attention as an alternative to institutionalization.

   A. Discuss some of the advantages of this type of living arrangement.

   B. Describe some of the types of problems that you could foresee arising within the foster home setting.

X. INSTRUCTIONAL STRATEGIES

1. Objective: To increase understanding of some of the various options to institutionalization that are available to many older persons.

Method: 1) Divide participants into at least four groups. Make arrangements for each group to visit one of the following settings: an adult foster care home, a day hospital, a senior citizen apartment housing complex, a halfway house, and any other relevant type of option. Have each group report its findings to the entire group.

2) Invite a panel of representatives from some of the various options to speak about their programs. Have them address topics such as magnitude of the program, recruitment of staff and residents, costs, and strengths and weaknesses of the program.

2. Objective: To move toward a greater empathic understanding of life in an adult foster care home.

Method: Divide into groups of six persons. Within each group, have one person assume each of the following roles:

- The caretaker. A 45-year old woman. She has been a foster care provider for the past five years.
- Her husband. He is employed during the day and thus is at home only during the evening.
- An 18-year old son or daughter. He or she is a student at the local university and holds a part-time job.
- A 65-year old resident. This person suffered a heart attack 3 years ago. He/she has lived in the foster home for 14 months.
- An 83-year old resident. Except for a hearing problem, this person is in relatively good health. A tendency toward occasional confusion led to

his/her placement in this home 26 months ago.

- A 72-year old resident. This person moved into the foster home last month after living alone in his/her own home for the past 21 years. He/she was very reluctant about the move and is having some difficulty adjusting to this new environment.

Allow five minutes for each person to think about how he/she will interact in his/her role. Then, permit each group to move to a location where they will be afforded maximum privacy. The setting for the role play is the family living room shortly after dinner.

Ideally, one and one-half to two hours should be allocated for this role play, since participants will need an ample amount of time to work into their roles.

After the role play, have members discuss with one another their feelings and impressions of the experience.

XI. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F About 75% of all persons are institutionalized at some time in their lives.

2. T or F Most recipients of in-home services require a combination of two or more services to meet their needs.

3. T or F Sheltered housing is considered a "semi-institutional" alternative to institutionalization.

4. T or F Senior citizen housing is a form of sheltered housing.

5. T or F Congregate housing provides for greater privacy than is found in traditional housing arrangements.

6. T or F Rehabilitation to previous levels of physical and mental functioning is an important goal of sheltered housing with elderly clients.

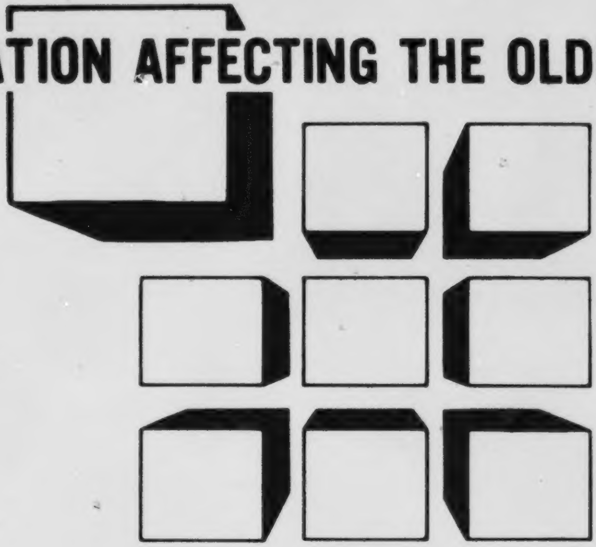
7. T or F Foster care for adults is based on the notion that the family is the most appropriate social unit for providing care.

8. T or F According to Sherman and Newman, most neighbors of foster care homes for adults object to such housing.

PRE-AND POST-KNOWLEDGE QUESTIONS KEY

1. F
2. T
3. T
4. F
5. F
6. F
7. T
8. F

LEGISLATION AFFECTING THE OLDER ADULT



I. Training Goal 351

II. Cognitive Objectives 351

III. Affective Objectives 351

IV. Outline 352

V. Sample Lecture 353

VI. Annotated Bibliography 379

  A. Books 379

  B. Periodicals 380

VII. Brochures and Pamphlets 382

VIII. Audiovisual Aids 386

IX. Discussion Questions 388

X. Instructional Strategies 389

XI. Pre-and Post-Knowledge Questions/Key 390

I. TRAINING GOAL

To present the major pieces of federal legislation affecting the elderly, with emphasis on those enabling the client to remain independent and in his or her own home as long as possible. To create an awareness of the complexity and changing quality of legislation.

II. COGNITIVE OBJECTIVES

- describe some of the types of legal problems affecting the elderly
- list eligibility standards and regulations governing the various titles of the Social Security Act
- enumerate the national goals of Title XX of the Social Security Act
- identify and differentiate between the various titles of the Older Americans Act
- describe some of the legislation other than the Social Security and Older Americans Act which affect the elderly
- identify sources for updating and refining legislative information for the elderly

III. AFFECTIVE OBJECTIVES

- develop a willingness to search through the maze of legislation in an effort to secure that information needed by the client to derive the benefits for which he or she is entitled
- understand the frustration that is felt by many older persons who attempt to obtain the services for which they are eligible

IV. OUTLINE

A. Introduction

B. Federal Programs
1. The Social Security Act
a) Title II - Old Age, Survivors & Disability Insurance Program (OASDI)
b) Title XVI - Supplemental Security Income (SSI)
c) Title XVIII - Medicare
d) Title XIX - Medicaid
e) Title XX - Social Services
2. The Older Americans Act
a) Title III - Grants for State and Community Programs on Aging
b) Title IV - Training and Research
c) Title V - Multipurpose Senior Centers
d) Title VII - Nutrition Program for the Elderly
e) Title IX - Community Service Employment for Older Americans
3. Other Legislation
a) Food Stamp Program
b) Transportation Programs
i. National Mass Transit Act of 1974
ii. Section 16(b) of the Urban Mass Transportation Act of 1964
c) Housing and Community Development Act of 1974
i. Section 8, Housing Assistance Program
ii. Section 202, Direct Loans for Housing for the Elderly
d) Comprehensive Employment and Training Act of 1973
i. Title II
ii. Title III
e) Domestic Volunteer Service Act of 1973
i. Foster Grandparent Program
ii. Retired Senior Volunteer Program
iii. Senior Companion Program
iv. Service Corps of Retired Executives

C. New York State Programs
1. Real Property Tax Law
a) N.Y.S. Real Property Tax Law - Sections 467 and 467
2. Social Services Law
a) Emergency Assistance for Adults

D. Sources of Legislative Information
1. Social Security Administration
2. Department of Social Services
3. Office for Aging
4. Elected Representatives

E. References

V. SAMPLE LECTURE

A. Introduction

Caseworkers are often in a position to help elderly clients sort through the maze of legislation which impinges upon their lives. Such help may take the form of directing the client to another agency and assisting him or her in dealing with that agency, or it may involve the recognition that professional legal assistance is required and an attempt to help the client find that professional help.

There are numerous problems which can serve to hinder the attempt of an elderly client to secure his or her rights to certain benefits. Three of these problems will be discussed.

The first type of problem a client may have is a basic lack of information. Social Services personnel can often answer questions pertaining to such issues as the appropriate age to apply for Social Security, eligibility for special housing, and how to make application for survivors' benefits. The ability to answer such basic questions enhances the opportunity to directly aid the client. When sufficient knowledge cannot be obtained by the worker from handbooks or other agency publications, workers should know whom to call to secure the necessary information.

The second type of problem a client might encounter centers on the logistics which might be involved in procuring the desired service(s). The client may need, for example, to obtain a copy of his or her birth certificate to prove eligibility for a program. Very often, the caseworker will have the expertise to solve such a problem; however, it often may be necessary to refer these clients to a lawyer for professional legal advice. Caseworkers need to develop the ability to sort out those problems which they can handle from those which need professional advice.

The third type of problem a client may have is what is popularly known as being caught up in "red tape." A caseworker may be able to expedite an application if the agency knows the caseworker is helping the applicant as well as keeping track of the agency's actions. In some cases, however, no amount of prodding or gentle persuading will help. Then, it is up to the caseworker to see that the client remains safe while waiting for the application to be processed.

Since any of these problems may occur when dealing with either federal or state programs, it will be advantageous for caseworkers to be familiar with the mechanism of the full range of programs available in order to benefit the client to the highest degree possible. Not every area of the state will have all of the programs discussed in this section, nor will every program be appropriate for each client. It is important to remember, however, that the skillful worker will help the client to take advantage of as many programs as are desired and needed.

B. Federal Programs

Prior to the enactment of the Social Security Act in

1935, action on the part of the federal government in behalf of older people was minimal. However, in the ensuing 40 years, the scope of programs has developed to such an extent that it would be impossible to give complete coverage here. Instead, this section will attempt to introduce some of the major legislative programs affecting older Americans.

1. The Social Security Act

a) Title II - Old Age, Survivors and Disability Insurance Program

Social Security is the nation's basic method of providing a continuing income when family earnings are reduced or halted because of retirement, disability, or death. When the original Act was passed in 1935, it provided only for retirement insurance. Amendments were added in 1939 to provide benefits for dependents and survivors and in 1956 to provide disability insurance.

At the time of the enactment of the Social Security legislation, it was thought that workers would also have private pensions and savings to fall back on. However, many companies did not offer pension plans or withdrew them, thinking that Social Security would be sufficient. For many individuals, saving was impossible since wages were low, and for those who did save, inflation has eroded whatever amount they had set aside. Consequently, alghough it was never intended as total income, the retirement section of the program is one of the primary economic supports for older Americans.

The main points of the program are:

1. Work related - Worker's entitlement to benefits and amount of benefits are derived from average earnings over most or part of one's working history.

2. Compulsory - Participation in the program is mandatory except for certain state and local government employees, some part-time irregular workers, and federal civilian employees.

3. Contributory - Workers pay to help finance the program.

4. No means test - Since program is compulsory and contributory, benefits are paid whether needed or not. However, benefits must be applied for.

5. Earned right - The conditions and amount of payment are specified by law and depend upon retirement age.

6. Program of change - Congress and the administration are constantly investigating and improving the program; there are usually yearly changes.

Survivors insurance provides benefits to certain members of the worker's family if the worker dies.

For a fuller explanation of which family members qualify and at what age, consult the Social Security Administration (SSA). A lump sum payment can also be made to the spouse when the worker dies. This is a one-time death payment and should not be confused with monthly cash benefits.

Disability insurance provides workers with protection against loss of earnings due to total disability. In general, a worker is considered disabled only if a severe mental or physical condition prevents substantial gainful activity and only if this condition is expected to last (or has lasted) for at least 12 months, or if the condition is expected to result in death. Such factors as age, education, and work experiences are considered along with medical evidence in making a disability decision.

b) Title XVI - Supplemental Security Income

Since not all occupations were covered originally by the retirement insurance program, workers in industries not covered by the Act and workers who never worked steadily arrived at retirement only to find themselves impoverished. To relieve the burden of these elderly without funds, the Old Age Assistance Act of 1950 (OAA) was enacted to furnish a minimum monthly income. Because the program carried with it connotations of charity, OAA served for many only as a last resort. In 1974, OAA was replaced by the Supplemental Security Income (SSI) program. As with retirement insurance, SSI is not meant to provide total financial assistance. Rather, SSI is an income maintenance program to provide a minimum income floor for the aged, blind, or disabled. This is done by providing monthly checks of an amount to ensure that the recipient has a basic cash income. The amount varies depending on other income the recipient might receive.

In New York State, the total SSI payment is derived from two sources: the basic federal payment and a New York State supplement that varies according to the recipient's living arrangements. New York supplements the federal payment to maintain the level of assistance recipients were formerly receiving under the Old Age Assistance Act. This provision for mandatory state supplementation was put into law to protect former recipients against any reduction of income as a result of the changeover to SSI. States have the option, however, to supplement the federal payment to newly eligible beneficiaries, and New York does provide this supplement. Benefits are administered through the Social Security Administration.

Eligibility requirements for SSI are uniform throughout the nation. The requirements are:

1. Age - 65 or over

2. Income - Amounts are set per month for an individual and for a couple. These national figures are subject to change and, thus, are not quoted here; it is best to consult with SSA for the amounts. A person may have income above the national level and be eligible for a state supplement only.

3. Resources - A cash amount has been set for an individual and for a couple. Again, consult SSA for amounts. Some resources, such as a home, car, personal effects, and household goods of reasonable value, do not count as assets in most cases.

c) Title XVIII - Medicare

A national health insurance program was considered for inclusion in the Social Security Act of 1935. However, it wasn't until 1950 and the passage of the Old Age Assistance Act that a federal program addressed the issue of health services. OAA helped to ease the burden of medical expenses for the indigent elderly, but it failed to provide any assistance for the vast majority of older Americans. In 1965, two health programs were passed. These programs are Medicare and Medicaid.

Medicare is a health insurance program for people 65 and older and some people under 65 who are disabled. The Medicare program supplements, but does not supplant, the individual's responsibility for his medical care expenses. For example, routine physical checkups, prescription drugs, routine eye examinations, and eyeglasses are not covered by Medicare; it is up to the individual to cover the full cost of these services. A shortcoming of Medicare is that it allows no provisions for preventive care; rather, it is based on the medical model, where services are provided only when the health situation is acute.

Medicare is comprised of two parts. Part A of the program provides basic hospitalization insurance and is automatic for all who qualify for Social Security. Part B provides medical insurance and is open for voluntary enrollment at a fee which is then withheld from Social Security payments. The services provided under Medicare, the amount of the deductible, and the benefit periods are subject to frequent change. Thus, for specific information as to what is and is not covered, the SSA should be consulted.

d) Title XIX - Medicaid

Unlike Medicare, Medicaid is not an insurance program and recipients are under no obligation to pay either fixed premiums or costs for services. The program is for the medically indigent. For example, SSI recipients are automatically eligible for

Medicaid. Other criteria for eligibility are devised by the states and are based on economic need. These criteria, as well as the services covered by the program, are subject to frequent change. Application for the program is made through the local departments of social services. Medicaid is funded by both federal and state monies.

e) Title XX - Social Services

Under Title XX, states are allocated federal funds for social services. Hence, it is up to the state and local districts to decide what services they will make available and how the services will be delivered. These services, however, must be directed to one of five nationally set goals:

1. Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;
2. Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
3. Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, or reuniting families;
4. Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of

less intensive care;

5. Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

The state has selected and defined twenty-one services which may be funded under Title XX. These are outlined in the Comprehensive Annual Social Services Program Plan. Local districts can decide, to a certain extent, which of these service programs they will provide and for whom they will provide. Several of the 21 programs, such as protective services for adults and children, as well as information and referral services, are mandated to be provided by the state and must be provided to anyone regardless of his or her income or resources. Some services are mandated for those eligible for SSI. Among these programs are home management, homemaker, housekeeper/chore, housing improvement, and health-related services. Other services, such as transportation and employment services, are not required and the local district has the option of deciding whether to offer the service, and if so, to whom.

Once local districts decide which services they will deliver, they still have flexibility as to how they will provide them. There are three major ways in which local districts can provide services -

through direct provision, purchase private, and purchase public. Direct provision is where the services are provided by the local districts themselves. Purchase private is where the local district contracts with a private profit or nonprofit agency to provide the service. Purchase public involves contracting with a public agency to provide the service.

Regardless of which delivery system is selected, local districts retain responsibility for individual case management. This responsibility includes developing a service plan after consultation with the client, establishing a service goal with the client, and providing the service to the client by one of the three methods.

2. The Older Americans Act

This Act, passed in 1965, was the next significant turning point in the provision of leadership and services for the elderly by the federal government. The Act created the Administration on Aging (AoA), put into law 10 objectives that state the rights to which older Americans are entitled, and created three operating programs in AoA. As with the Social Security Act, this Act has been amended many times. At present, the following titles of the Act are the most significant to those working with the elderly at the local level.

a) Title III - Grants for State and Community Programs on Aging

This title provides for strengthening state agencies on aging and establishing a national network of Area Agencies on Aging (AAA). The objective of the program is to improve or develop a system of coordinated and comprehensive services for older persons at the state and local levels in order to enable the aged to maintain independence in their own homes or other places of residence in the community for as long as possible.

Often, services to the elderly at the local level are fragmented or duplicative. The Area Agency on Aging is intended to become a focal point in the community; to plan services for older adults, particularly for the low-income and minority elderly person; and to coordinate community resources and other titles of the Older Americans Act. In New York State, virtually all AAA's correspond to county jurisdiction and are called County Offices for Aging (COFAs). Since the majority of AAA's were created in 1974, it will probably be some time before the effectiveness of the community approach to federal programs can be adequately evaluated.

An Area Agency may offer direct services itself if it were providing the service before Title III was formalized or if no other agency in the community were providing the service. If the agency discovers a need in the community for such programs as home repair, winterization, or homemaker service, it is authorized to spearhead efforts to see that the service is incorporated into the community's programs.

b) Title IV - Training and Research

In order to improve the quality of services for older persons and to help meet critical shortages of adequately trained personnel for programs in the field of aging, this title provides funding for training and research. This can be provided in a number of ways. The most important way for the caseworker is by providing a range of training and retraining opportunities responsive to the changing needs of programs in the field of aging.

Funds are available through the local Area Agency on Aging to persons who are employed or are preparing for employment in aging-related fields. These funds can be used to assist in paying the costs of programs, such as training courses, workshops, college courses, and seminars, in order to improve the capabilities of the participants to provide services to older persons.

c) Title V - Multipurpose Senior Centers

This title provides funds for the acquisition, alteration, or renovation of buildings to serve as centers for senior citizens. Multipurpose senior center refers to a community facility that will provide for a broad spectrum of services for the older person, such as health, social, and educational services, along with recreational activities.

d) Title VII - Nutrition Program for the Elderly

The purpose of this program is to assist communities in meeting the nutritional needs of older people. The program attacks two problems from which many low-income, disabled, or minority-group elderly suffer: poor nutrition and loneliness. Low-cost, nutritionally sound meals are offered from strategically located centers in close proximity to the target population. There are no means tests or applications for the program. It is available to anyone over the age of 60 or the spouse of someone over 60 and strives to reach those who:

- cannot afford to eat adequately;
- lack the skills to select and prepare nourishing and well balanced meals;
- have limited mobility which impairs ability to shop and cook; or
- have feelings of loneliness and rejection which obliterate the incentive to prepare and eat a meal alone.

Other needs of the elderly are also addressed by supportive services the meal sites offer, including transportation and escort service to and from the site; outreach; shopping assistance; nutrition education; recreation; health and welfare counseling; and information and referral. Nutrition projects are able to offer all these services by coordinating their programs with other providers of social services in the community. Thus, beside offering meals, the program helps to provide a sense of community for a distinct client population.

Some meal sites deliver meals to homebound elderly in their immediate vicinity. These "Meals-on-Wheels," as they are popularly called, are very much needed; however, Title VII is designed primarily for group dining. (As of this writing, Congress is working on legislation to amend the Older Americans Act to add a title specifically for Meals-on-Wheels.)

e) Title IX - Community Service Employment for Older Americans

This title provides funds for part-time employment in community service activities for the unemployed, low-income person who is at least 55 years of age and who has poor employment prospects. Although part of the Older Americans Act, the program is administered by the Department of Labor which subcontracts with five national sponsoring organizations to provide the bulk of employment. The organizations are:

1. National Farmers Union (Green Thumb and Green Light);
2. National Council on Aging (Senior Community Service Programs);
3. National Council on Senior Citizens (Senior Aides);
4. National Retired Teachers Association/ American Association of Retired Persons (Senior Community Service Aids);
5. U.S. Forest Service of the Department of Agriculture. (Unfortunately, there are no programs through this agency in New York State.)

The remainder of funds go to localities in which community service projects are most needed. Funds from this title might also be used to coordinate job opportunities with those available under the Comprehensive Employment and Training Act of 1973.

3. Other Significant Legislation

a) Food Stamp Program

In addition to the Title VII congregate dining program, the Food Stamp program was created in 1970 to improve the levels of nutrition among low-income families. The program is administered nationally by the U.S. Department of Agriculture's Food and Nutrition Service, and locally by departments of social services. At this writing, participants in the program purchase an amount of coupons worth more than the sum paid, with the payment determined by family size and net monthly income. However, Congress under President Carter's leadership is in the process of reforming the food stamp program. The major revision would be to eliminate the purchase requirement.

Provided that the individual is homebound, food stamps may be used by those 60 years of age or older to purchase home delivered meals from a nonprofit meal service.

b) Transportation Programs

Transportation and mobility are crucial considerations in determining whether the necessities of life will be secured and in determining opportunities for human interaction.

As mentioned earlier, transportation services are mandated to be provided to meal site participants under Title VII of the Older Americans Act. Transportation can also be provided under Title III of the Older Americans Act and Titles XIX and XX of the Social Security Act. Two additional programs exist to help the elderly increase their mobility.

i. The National Mass Transit Act of 1974

This act provides for reduced fares for older persons. If a transit service company is receiving funds under Section 5 of the Urban Mass Transportation Act of 1964, the company is required to provide transportation at not more than half-fare to elderly and handicapped persons during non-peak hours.

ii. Section 16 (b) of the Urban Mass Transportation Act of 1964

This section allows the Department of Transportation to make grants to state or local government or public agencies for the purchase of vehicles and equipment so urban programs can improve transportation for the elderly. Also, funds are available for capital assistance grants to private, nonprofit associations to help them provide transportation services for the elderly and handicapped. Thus, a local government or a private agency, such as a senior citizen center, can receive funds to purchase a van to transport senior citizens.

c) Housing and Community Development Act of 1974

Many older Americans suffer from a lack of adequate housing. Not only is there not enough housing for the aged, but what is available may be unfit for habitation. Many elderly persons also pay a disproportionate amount of their income for rent or home ownership. The Housing and Community Development Act of 1974 was a milestone in housing legislation. There are two significant sections which affect the elderly.

i. Section 8, the Housing Assistance Program

Section 8 provides a rental subsidy for eligible low and moderate income persons. The amount of assistance is equal to the difference between the family's ability to pay and the established maximum rent for the unit.

ii. Section 202, Direct Loans for Housing for the Elderly

Section 202 provides loans to eligible sponsors (nonprofit and limited-profit corporations, consumer cooperatives or public agencies) for the construction of housing for the elderly and handicapped.

Section 202 was actually reinstated through this legislation, HUD having ceased funding the program in 1969.

d) Comprehensive Employment and Training Act of 1973

CETA addresses itself to the needs of disadvantaged groups, including the older worker. The purpose of CETA is to provide job training and employment opportunities for the economically disadvantaged, unemployed or underemployed person, regardless of age. Two titles are especially relevant to the older employee:

i. Title II of the Act provides employment opportunities in public service jobs. This title can be utilized by community agencies to supplement their work force so as to increase service delivery.

ii. Title III specifies that employment opportunities will be adequately furnished to segments of the population that are in particular need, such as to older workers.

Along with Title IX of the Older Americans Act, CETA provides the opportunity for many older persons to continue to make valuable contributions to the work force.

e) Domestic Volunteer Service Act

The United States has traditionally been a work-oriented society, and the individual's value has been tied to the work he or she has performed. Under these conditions, it is difficult for many to adjust to retirement. Not only does income become drastically reduced, but social contacts also diminish appreciably. Programs such as those previously discussed under Title VII of the Older Americans Act do much to foster socialization and promote recreation. However, older people may also wish to continue using their skills to help others and to make a contribution to the community. There are several programs under the Domestic Volunteer Service Act of 1973 which provide the older person with the opportunity to work part-time with children, other older people, and businesses. Some of these programs, such as RSVP and the Foster Grandparent Program, were incorporated into this Act when Title VI of the Older Americans Act was repealed. Some of these programs are:

i. The Foster Grandparent Program - This program offers opportunities to low-income men and women, age 60 and over and in good health, to provide love and attention to physically, emotionally, and mentally handicapped children in institutions and private settings.

ii. Retired Senior Volunteer Program - Through this program, retired men and women age 60 and over can serve in a variety of agencies, including schools, libraries, courts, hospitals, day care centers, and nursing homes.

iii. Senior Companion Program - This program, patterned after the Foster Grandparent Program, provides opportunities to serve adults with special needs - especially the elderly - in their own homes, in nursing homes, or in other institutions.

iv. Service Corps of Retired Executives - SCORE is a program which links retired businessmen and women who have management expertise with the owners or managers of small business and community organizations in need of management counseling.

C. New York State Programs

State legislation will not be covered because of its changing quality and differing eligibility requirements from locality to locality. However, two programs are of special interest to caseworkers.

1. Real Property Tax Law

Section 467 of the New York State Real Property Tax Law enables local taxing jurisdictions to grant property tax exemptions to older people who own their homes. These exemptions are subject to certain income requirements which vary between localities. The New York State Board of Equalization and Assessment is responsible for monitoring local implementation of real property tax relief. To determine whether a specific locality has implemented the program, it is best to contact the County Assessor or County Director of Real Property Tax Services. These local officials will also be able to explain the deadlines for filing the exemption forms, which usually do not coincide with the taxing year.

2. Social Services Law

Emergency Assistance for Adults (EAA) is a program designed to meet emergency needs of individuals and couples who have been determined eligible for or are receiving SSI, but whose specific need cannot be met by the SSI program. Emergency needs are those needs which if not met would endanger the health, safety or welfare of the eligible persons.

There are fourteen circumstances under which the local department of social services may grant funds to meet emergency needs. These are spelled out in a departmental administrative letter, transmittal No. 76 ADM-110, which should be consulted for procedure.

D. Sources of Legislative Information

Because of the changing quality of legislation and programs affecting the elderly, it will be necessary to continually update your knowledge of the procedures of how to apply for programs, eligibility requirements, etc. Listed are some sources of additional information on the interpretation of legislation.

1. Social Security Administration

Both the regional and local offices will provide specific information on the programs they administer by providing brochures, films, or speakers. The local offices are listed in the phone book; for the Region II office (New York, New Jersey, Puerto Rico, and the Virgin Islands), write or call:

Regional Commissioner
Social Security Administration
26 Federal Plaza
New York, New York 10007
(212-264-3915)

2. Department of Social Services

Some local departments employ a legislative counsel to interpret laws; others do not. If your department does not have a counselor or consultant lawyer, the main office of DSS, particularly the Legislation or General Laws unit of the Office of Legal Affairs, should be consulted for specific advice. In addition, department manuals containing bulletins should be reviewed. These bulletins are written to provide guidelines on the provision of different services.

3. Office for Aging

The local county Office for Aging should be consulted first for information on programs under the Older Americans Act. If necessary, the State Office for the Aging can be contacted for information on new legislation affecting the elderly. Call or write:

New York State Office for the Aging
State Agency Building #2
Empire State Plaza
Albany, New York 12223
1-800-342-9871 (Toll Free) or
(518-474-6252)

4. Elected Representatives

Elected representatives should not be overlooked as a source of information on legislation and legislative programs. Additionally, since a Congressional office or Congressman command instant attention from federal, state, and local agencies, they can be asked to assist if a case gets tied up in "red tape."

E. References

Beattie, W.M. Aging and the social services. In R.H. Binstock & A. Shanas, (Eds.), Handbook of aging and the social sciences. New York: Van Nostrand Reinhold Co., 1976.

Eight facts about section 8. (U.S. Department of Housing and Urban Development, HUD-388-F2). June, 1976.

Employment and volunteer opportunites for older people. (U.S. Department of HEW, Fact Sheet No. OHD 76-20233). June, 1976.

Federal action for aging began in 1930's. What has happened since? Aging. U.S. Department of HEW, No. 247, 1975, 13-26.

Hendricks, J., & Hendricks, C.D. Aging in mass society. Cambridge: Winthrop Publishers, 1977.

Implementation of 1971 White House conference on aging recommendations. (Hearing before the Select Committee on Aging, House of Representatives.) August 25, 1976.

Lange, J.D. Local action programs: Housing for older Americans. (Prepared for the National Forum on Aging for local government officials.), 1974.

New York State Department of Social Services, Emergency assistance for adults. Administrative letter 76 ADM-110, October, 1976.

New York State Department of Social Services, Final comprehensive social services program plan for New York State. October, 1976.

New York State Legislative Commission on Expenditure Review. Programs for the aged. 1975.

Rosencranz, H.A. Pre-retirement education: A manual for conference leaders. Storrs, Connecticut: The University of Connecticut, 1975.

Syracuse University All-University Gerontology Center. An instructor's handbook for the development of a basic course in gerontology. (Prepared under a contract with the New York State Office for the Aging.) November, 1975.

Toward a national policy on aging, volume II. (Proceedings of the 1971 White House Conference on Aging.) Washington, D.C.: U.S. Government Printing Office, 1973.

Van Woert, K., & Hollander, E. The world of our aging: A study of the elderly in New York State. (Prepared for Joint Select Committee on Problems of the Aging, New York State Legislature.) Undated.

U.S. Department of Health, Education, and Welfare. A Guide to supplemental security income. (Publication No. SSA 76-11015.) Washington, D.C.: U.S. Government Printing Office, 1976.

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Blong, A., Leyser, B., & Cole, S. (Eds.) *Supplemental security income: Advocates handbook*. New York: Center on Social Welfare Policy and Law, 1975.

The handbook explains who is eligible for the Supplemental Security Income program and how the program is administered. Although written for lay advocates in welfare rights groups and other groups or agencies that work with the elderly, blind or disabled poor, the handbook is relevant for caseworkers to sensitize them to the rights of the elderly.

Myers, R.J. *Social security*. Homewood, Illinois: McCahan Foundation, 1975.

This book provides a thorough, factual description of the various social insurance and allied programs now operating in the United States, such as Old Age Survivors Disability Insurance (OASDI), Medicare, Railroad Retirement, unemployment insurance, and workmen's compensation. The emphasis is on both the general principles underlying the development of the systems and their present status, and on the general social and economic results developing from them.

Neugarten, B.L., & Havighurst, R.J. (Eds.). *Social policy, social ethics, and the aging society*. (Report prepared for National Science Foundation by Committee on Human Development, Univ. of Chicago.) Washington, D.C.: U.S. Government Printing Office, 1976.

This report contains a collection of articles pertaining to issues of social policy regarding the quality of life of older Americans. The report is divided into three sections. The first section provides an overview of policy toward aging in the United States. In the second section, the focus is on income and economic aspects of later life. The final section discusses the issue of health services and the elderly.

Pechman, J.A., Aaron, H.J., & Taussig, M.K. *Social security perspectives for reform*. Washington, D.C.: Brookings Institution, 1968.

The book presents an excellent historical perspective on the development of the OASDI program and provides insight into the economic status of the aged.

Witkin, E. The impact of medicare. Springfield, Illinois: Thomas, 1971.

This book examines the history of previously existing health plans and the resulting Medicare law. It describes the size, cost, and procedures of the program and is geared to educating the lay reader as well as the professional. It concludes by speculating on the future role of Medicare.

B. Periodicals

Burr, J.J. Delineating the ramifications of Title XX. Perspective on Aging, 1975, 4(6), 14-19.

This article clearly outlines what Title XX is, particularly in regard to the aged. It discusses what Title XX can accomplish by replacing previous legislation. It concludes by discussing the need for coordinated planning efforts with other federal programs for the aged, such as those under the Older Americans Act.

Federal action for aging began in 1930's: What has happened since? Aging, 1975, 247, 13-26.

This concise and informative article describes the origin and evolution of federal involvement in the aging field. Beginning with the Social Security Act of 1935 and concluding with the 1973 amendments to the Older Americans Act, the article describes the needs that brought about the various federal programs and the operation of the Administration on Aging.

Hollister, R. Social mythology and reform: Income maintenance for the aged. The Annals of the American Academy, Sept. 1974.

This article reviews the major changes in the social security system following the 1972 amendments; it also presents historical developments leading to such reform.

Medicare and medicaid after ten years. Editorial Research Reports. Volume II, July 18, 1975.

This report looks at developments in the history of Medicare and Medicaid over the past ten years. It outlines how the system operates and also describes the investigations into health care fraud and abuse.

Oriol, W., & Affeldt, D. Federal directions for the aged. Social Policy, Nov./Dec., 1976, 76-80.

This article describes the federal impetus for the creation of senior service programs, such as the Green Thumb program.

VII. BROCHURES AND PAMPHLETS

Fact Sheet: Employment and Volunteer Opportunities for Older People (Publication #[OHD] 76-20233)

The fact sheet offers information on where to look for jobs or volunteer work and on how additional income affects social security payments.

Available from: Office of Human Development
U.S. Department of Health,
Education and Welfare
Administration on Aging
National Clearinghouse on Aging
Washington, D.C. 20201

The Food Stamp Program (Publication #PA-1123)

A complete and comprehensive booklet outlining the program, its service, and eligibility.

Available from: Department of Social Services
Forms and Publications
800 North Pearl Street
Albany, New York 12207
(518) 474-2102

Golden Page

Agencies with a high proportion of elderly will find this monthly publication of the National Center on Black Aged informative. Areas of interest include legislation and political developments affecting black elderly.

Available from: National Center on Black Aged
1730 M Street, N.W.
Suite 811
Washington, D.C. 20036

A Guide to Supplemental Security Income (SSI) (Publication #[SSA] 75-11015)

Supplemental security income is a federal income maintenance program for the aged, blind, and disabled effective January, 1974. This guide delineates eligibility, benefits, and how to apply.

Available from: U.S. Department of Health,
Education and Welfare
Social Security Administration
Washington, D.C.
or
Local SSA

Older Americans and Transportation: A Crisis in Mobility

This 1974 publication is a five-part Senate report on problems and progress of transportation systems for the elderly. Prices on request.

Available from: The Senate Committee on Aging
Room G-225
Dirksen Senate Office Building
Washington, D.C. 20201

Program Introduction: The Social Security Program and the Supplemental Security Income Program

This concise and informative booklet is designed to orient the caseworker to the development and implementation of services through the Social Security Administration. The booklet was designed specifically for trainers.

Available from: Office of Management and Administration
Office of Human Resources
Division of Training and Career
Development
4P-10 Annex
Baltimore, Maryland 21235
(301) 594-3926

Significant Laws for the Aging: New York State Senate Committee on Problems of the Aging

A compilation of laws affecting the elderly introduced in the Senate is usually published yearly by Senator John Flynn's office.

Available from: Senator John Flynn
New York State Senate
Legislative Office Building
Room 307
Albany, New York 12248

Special Committee on Aging: U.S. Senate

The U.S. Senate Special Committee on Aging has on file and for public use reprints of works of the Committee. These reports have a wide range of interest: health and economic status of older Americans, medical assistance, developments and trends in state programs and services for the elderly, and nursing home care in the U.S.

Along with continuing newsletters from the Senate Committee, these reports are available from:

Ms. Patricia G. Oriol, Chief Clerk
Special Committee on Aging
U.S. Government Printing Office
Washington, D.C. 20036

Your Guide to the State Senate

This brochure describes how to get copies of bills; how to find the status of bills; how to obtain a senator's voting record; what standing committees are; how to file petitions; and how to write to your senator.

Available from: Your local State Senator
Legislative Office Building
Empire State Plaza
South Mall
Albany, New York 12248

Your Social Security (Publication #[SSA] 76-10035)

This booklet describes how the individual earns protection under Social Security, the kinds of benefits the individual and his/her family can get, how Social Security is financed, and information to help plan for the future.

Available from: U.S. Department of Health, Education and Welfare
Social Security Administration
Washington, D.C.
or
Local SSA

1977 Federal and State Legislative Program

This brochure was prepared to bring the needs of older Americans to the attention of national and state legislators. Problems and inequities in the Social Security system are pointed out, as well as problems in other health and employment programs.

Available from: National Retired Teachers Association/
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

VIII. AUDIOVISUAL AIDS

MEDICARE: HOW IT HELPS YOU

16 mm film/Color
29 minutes, 1974
Available from: Social Security Administration

A case history approach is used to explain some of the services provided by Medicare, such as in-hospital care, extended facilities care, and home health care. This film should be used in conjunction with the brochure Your Medicare Handbook (SSA-74-10060).

THE SOCIAL SECURITY STORY

16 mm film/Color
15 minutes, 1970
Available from: Syracuse University
Rental only - Previews on special request

Dramatized incidents are used to inform the viewer about old age and disability insurance programs. The film explains how social security is contributory by both employee and employer and that with retirement, disability, or death, payments will be made to the employee and/or his dependents.

THAT THE LAST BE THE BEST

16 mm film/Color
28 minutes, 1973
Available from: New York State Office for the Aging, Film Service

This is a dramatic film on the problems of aging in the U.S., with a brief report on the initiatives of the 1971 White House Conference on Aging. It also includes film clips of President Nixon as he addressed the final session on December 2, 1971.

WHAT DOLLARS WON'T BUY

16 mm film/Black & White
22 minutes
Available from: New York State Department of Social Services

This orientation film describes some of the needs of the blind, aged, and disabled that are not fulfilled by financial assistance.

YOU'LL GET YOURS WHEN YOU'RE 65

16 mm film/Color
49 minutes, 1973
Available from: Carousel Films, Inc. or Pennsylvania State University

This film discusses the Social Security system by comparing it with Germany's program. It not only points up what is lacking in our system, but also dispels some misconceptions about our health and retirement systems. The Executive and Congressional viewpoints on retirement and health care are also discussed.

IX. DISCUSSION QUESTIONS

1. It has been said that the Social Security system is designed in a way that discourages older people from seeking other income.

   A) Do you think this is true?

   B) What is your opinion of the Social Security system?

   C) If you were able to make one change in the system, what would it be? Why?

   D) What can the service worker do to help the system better meet the needs of the client?

2. Many of the programs discussed in this module are optional at the local level.

   A) Has your county taken advantage of the available services?

   B) Do you see any areas where services could be developed or improved?

3. Although much has been done to improve social services for adults, there are still many unmet needs.

   A) What are some of these needs?

   B) Is there a need for more legislation?

   C) What kinds of action would you like taken?

   D) Is legislation best accomplished at the federal, state, or local level? Why?

4. Answer the following questions after considering the various titles of the Older Americans Act.

   A) How can programs from these titles be coordinated within one overall program, such as a multipurpose senior center?

   B) Do you feel that these titles adequately meet the multiple needs of the older adult? Why or why not?

X. INSTRUCTIONAL STRATEGIES

1. Objective: To stimulate discussion on the various federal programs; to create awareness of the complexity and changing quality of legislation.

   Method: Invite a panel composed of representatives from the Social Security Administration, Office for Aging, Department of Labor, Department of Transportation, local, federal or state legislators or staff.

2. Objective: To empathize with the older client as he or she struggles with the bureaucracy that impinges upon his or her life.

   Method: Participants fill out an application for Food Stamps or Supplemental Security Income.

3. Objective: To understand the limitations of legislative programs.

   Method: 1. Using Supplemental Security Income levels, small groups of participants prepare a budget. Discussion should follow on the adequacy of the budget; health, safety, nutrition and so on should be considered.

   2. Participants note when they go food shopping how much is spent on non-allowable items under the Food Stamp program. A report is made the next week in the group and discussion should follow.

4. Objective: To familiarize participants with resources in their community for the older client.

   Method: Visit a congregate dining site or a senior center. Questions could be prepared by participants in advance, such as, "What provisions are made for those unable to get to the site by themselves?" or "How did participants become involved in the program?" Participants should discuss the visit when training reconvenes.

XI. PRE-AND POST-KNOWLEDGE QUESTIONS

1. T or F In New York State the SSI payment is a total of two amounts, the basic federal payment and a New York State supplement.

2. T or F Medicare is comprised of two parts: Part A provides basic hospitalization; Part B provides medical insurance.

3. T or F Medicare is a comprehensive insurance program covering hospitalization; medical insurance; and preventive care, such as routine physical checkups.

4. T or F The state mandates that services, such as housing improvement, homemaker and housekeeper/chore service, be provided for those eligible for Supplemental Security Income.

5. T or F Local districts may enter purchase of service agreements with private profitmaking organizations for Title XX services.

6. T or F Title VII of the Older Americans Act states that anyone over the age of 60, or the spouse of someone over 60 who meets income requirements, is eligible for the Nutrition Program.

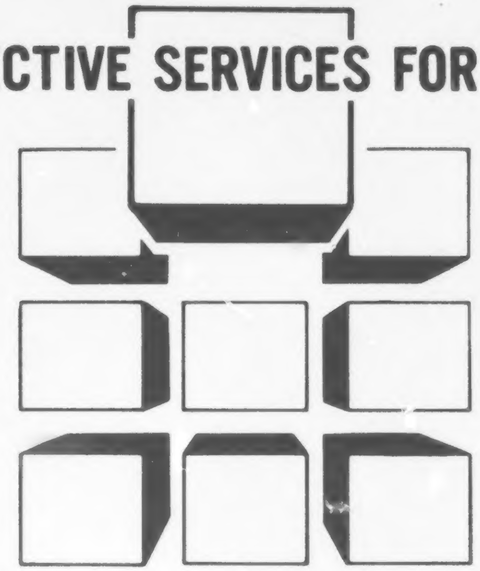
7. T or F The Community Service Employment title of the OAA provides funds for part-time employment in Community Service activities for the unemployed, low-income person who is at least 55 years of age and who has poor employment prospects.

8. T or F The Housing Assistance Program provides rent subsidies to low-and moderate-income persons based upon the difference between ability to pay and an established maximum rent.

PRE-AND POST-KNOWLEDGE QUESTIONS/KEY

1. T
2. T
3. F
4. T
5. T
6. F
7. T
8. T

PROTECTIVE SERVICES FOR ADULTS



I. Training Goal 395

II. Cognitive Objectives 395

III. Affective Objectives 395

IV. Outline 396

V. Sample Lecture 397

VI. Annotated Bibliography 415

A. Books 415

B. Periodicals 415

VII. Supplementary Reading Material 417

VIII. Brochures and Pamphlets 418

IX. Audiovisual Aids 419

X. Discussion Questions 421

XI. Instructional Strategies 426

XII. Pre-and Post-Knowledge Questions/Key 430

Appendix 1: Definition of Protective Services for Adults 432

Appendix 2: Case Simulation 434

I. TRAINING GOAL

To explore the concepts, mechanisms, and knowledge necessary for casework in Protective Services for Adults (PSA).

II. COGNITIVE OBJECTIVES

- distinguish a PSA case from a general services case
- recall legal doctrines governing the rights of the individual and the responsibility of government in situations concerning the client's civil rights
- identify the range of protective services and distinguish how they differ from one another
- describe the four characteristics of a PSA case
- demonstrate a knowledge of the types of problems a PSA client may exhibit
- distinguish between a voluntary and involuntary client and describe the implications for service delivery
- become familiar with legal concepts, techniques, and proceedings pertinent to the delivery of protective services
- identify the stages of the case management process and apply them to a realistic case situation
- know the local income requirements for free provision of service
- help to develop intraagency guidelines to insure internal support for PSA cases

III. AFFECTIVE OBJECTIVES

- become aware of the need for patience and understanding in dealing with the involuntary client
- empathize with the client's desire to control his/her life and to help him/her remain as independent as possible
- become aware of the need for cooperation with other agencies in order to insure a plan of comprehensive treatment for the multidimensional problems of the PSA client

IV. OUTLINE

A. Introduction

B. The Concept of Protective Services for Adults

C. Eligibility for Protective Services

D. The PSA Client

1. Characteristics
2. Problems of the PSA Client
3. The Voluntary and Involuntary Client

E. Client's Civil Rights Versus the Use of Authority

F. The Range of Protective Services

1. Social Protective Services
2. Legal Protective Services
3. Financial Management

G. Steps in the PSA Case Management Process

H. The PSA Professional Network

I. Role of the Agency in Relation to the Caseworker

J. References

V. SAMPLE LECTURE

A. Introduction

While the vast majority of older Americans are either capable of adequate self-care or have relatives or friends who can care for them, a minority are in need of protective services. It is estimated that of New York's two million persons over the age of 65, approximately 10%, or 200,000 persons, are in need of protective services.

The concept of protective services for adults is not a new one, nor is it a new service responsibility of the Department of Social Services. It is a service, however, that has been underutilized, possibly because of the characteristics of the clients in need of protective services. Withdrawal and/or social isolation may keep PSA clients relatively invisible in the community. Because of their debilitated state, these clients are usually the least attractive clients to workers, who generally prefer working with children and families. The service has also been underutilized because of the lack of adequate financial support. However, the passage of Title XX of the Social Security Act in 1975, which mandates delivery of Protective Services, makes it increasingly important for caseworkers to understand the nature of these services.

B. The Concept of Protective Services for Adults

Protective Services for Adults is a system of care designed to maintain individuals in the community as long as possible and, thereby, to forestall institutionalization.

Such services can be beneficial to the severely malfunctioning individual as well as to the person who is only marginally impaired. PSA encompasses what may be considered three functions: preventive, supportive, and surrogate. Bearing in mind that there is a great deal of overlap between these functions, the three categories can be placed on a continuum with the preventative and surrogate functions serving as the end points of the continuum.

The preventive function is based on early recognition of the potential need for assistance. Preventive services provide the client with information about services which will help maintain independent living, referral and encouragement to use the services, and follow-up. Services which may be brought to bear, in addition to information and referral, are physical and mental health clinics, screening and follow-up care, income maintenance, provision of adequate housing, recreational facilities, social activities, and pre-retirement, or other individual counseling.

Supportive services provide direct aid to the client and promote social autonomy by maintaining the best possible level of functioning. For example, supportive services include casework, counseling, homemaker services, visiting nursing, home-delivered meals, help with fiscal management, legal assistance, medical and psychiatric diagnosis and treatment, acute and convalescent hospital care, friendly visiting, and day care or foster home care.

The purpose of the surrogate function is to act in behalf of the client, with or without his or her consent, in order to secure necessary supportive services. Hall and Mathiasen note that since this function goes "to the limit of the need," it may involve the person's loss of control over property; loss of personal liberty, including guardianship or other fiduciary arrangements; and also may include incompetency proceedings and commitment. Thus, the use of legal authority will be necessary.

C. Eligibility for Protective Services

Title XX mandates that local departments of social services provide protective services for adults to all individuals over the age of 18 without regard to income. (These services are outlined in Bulletin 194 and briefly stated in Appendix 1.) If, however, additional services, such as transportation, are utilized in the client's plan, these can only be provided at no cost to those clients whose income is below the established income standard of the local district's Comprehensive Annual Social Service Program Plan. Therefore, it is important for caseworkers to be thoroughly familiar with the service plan and eligibility requirements of their own locality.

The exception to this is that Homemaker and Housekeeper/Chore Services may be provided at no cost to meet the goal of protection for adults who demonstrate specific functional deficits. The provision of such services is to be limited to six months when provided without regard to financial criteria and only when efforts to secure funding from the client or other resources have failed. However, if such a case is changed from PSA to general services status, the local district may no longer purchase services.

D. The PSA Client

1. Characteristics.

It is important to make a distinction between a general service case and a protective service case. The factors distinguishing these two types of cases lie in the characteristics, problems, and needs of the client and not in the nature of the services provided.

The characteristics which identify the client as needing protective services are:

Incapacity - the person is unable to care for himself or otherwise protect his own interests because of ignorance, diminished mental capacities, or poor health.

In danger - the person is harmed or threatened with harm which may result in physical or mental injury, neglect, or maltreatment either through action or inaction by another individual or through his own actions.

Unmet essential needs - the person is unable to secure adequate food, shelter, or clothing.

No one willing or able to assist - the majority of persons will be living alone and without responsible persons able, willing, or available to assist.

All four characteristics must be present in order for the client to be classified as needing protective service. If all four of these facts are not present, the client can still be given services. Here, however, the services will be general rather than protective.

2. Problems of the PSA client.

Those clients found to be in need of protective services can have any or all three major types of problems: physical, mental, or social. Although as stated, PSA is available for any individual over the age of 18, the focus here is on the older adult.

Physical - Such a person is too ill or feeble to act on his or her own behalf; the person may lack proper medical care and nourishing meals or health may be threatened by inability to maintain proper quarters or to manage clothing necessities.

Mental - This person suffers from impaired judgment or presents mental confusion due to either physical or psychological functioning.

Social - Perhaps because of a physical or mental problem, this client engages in a situation dangerous and injurious to her own life. This category includes those who are most difficult to reach and who create the greatest threat to themselves and to the community.

3. The voluntary and involuntary client.

Since PSA can involve the transfer of an individual's right to control his person, finances, and/or property, there is a need to distinguish between the client who seeks assistance and the client who does not want or refuses services.

Some individuals needing protective services will request the service or will be willing to accept the services when persuaded of their necessity. These clients are said to be voluntary clients. There are many individuals, however, who need protective services, and yet, despite extreme physical, mental, or social difficulties, do not understand the need for such help. These clients, usually referred by someone else, are said to be involuntary clients. Some involuntary clients can be moved to voluntary status by appropriate counseling and persuasion. However, this can be a very long and arduous process.

It is often the involuntary client who needs the protection of authoritative procedures. Here, the local agency needs to initiate action on behalf of those clients who exhibit dangerous or self-destructive behavior. However, there is a reluctance on the part not only of caseworkers, but also of physicians, police, mental health officials, and others to initiate services which seemingly deprive another individual of his or her constitutional rights. Thus, there is a need to understand the rights of the individual and the responsibilities of government.

E. Client's Civil Rights Versus the Use of Authority

The rights of the individual are upheld by various amendments to the Constitution. The Ninth Amendment provides "protection against all government invasions of the sanctity of a man's home and privacies of life." The Fourteenth Amendment provides that "(no) State (shall) deprive any person of life, liberty or property without due process of law."

The Constitution, therefore, prohibits government officials from entering a home, even to save a life, unless they have specific authority to do so under the law. Under these provisions, officials must allow the individual the right to determine one's own life style and the right to control one's own person and assets. However, while due process of law is a constitutionally guaranteed right held by every individual, there are traditional authorizations for intervention by law. The first of these is the common law principle of Parens Patriae that gives the State authority to act in a parental capacity for those incapable of self-care or for those who are dangerous to themselves. The second authorization is derived from the explicit power of the police to intervene in a situation if the health or safety of the society is jeopardized. Further, specific legislation in sections of the Social Services and Mental

Hygiene statutes give these agencies authority and responsibility to take action on behalf of the impaired adult. These laws, however, do not establish precise guidelines for determining at what point intervention is justified. Thus, it is often up to the caseworker and other case consultants, such as lawyers, physicians, and psychiatrists, to decide whether there is "substantial risk" to the individual or community. If such a risk is determined, the Social Services and Mental Hygiene statutes have authorized the agency to initiate appropriate actions.

These actions, however, must be what is referred to as the "least restrictive alternative." If government must interfere with an individual's life, liberty, or property, the Supreme Court has ruled in two cases (Roe vs. Wade, NAACP vs. Button) that such action must be limited to the alternative which is least restrictive in order to achieve the goal. Therefore, PSA caseworkers, as agents of the government, must abide by this concept. Caseworkers should provide assistance which will enable clients to maintain control of as much of their lives as they are capable of controlling.

F. The Range of Protective Services

Having determined that an individual is in need of protective services, the caseworker must insure that services are provided or can be obtained. Basically, protective services are of three types. These services can be thought of as a continuum. The services are social protective, legal protective, and financial management. Let's take a closer look at each of these categories of services.

1. Social protective services.

Social protective services include, but are not limited to, actions related to the activities of daily living, such as securing food, maintaining a home, and sustaining adequate physical and mental well-being. These services aim to secure assistance of family, friends, and other community resources in helping to meet the needs of the client. Social protective services help to minimize some of the problems faced by a client, improve his general condition, and sustain his personal functioning for as long as possible. The services also help to reduce anxiety or tension in the client, and in his family and neighbors.

Since case management and counseling form the core of all protective services and, to the extent that such case management is provided (e.g., enlisting and coordinating other services such as medical, psychiatric, and legal help for evaluation and treatment), all protective cases can be said to include social protective services.

2. Legal protective services.

Legal protective services reach beyond the assistance of family and friends and include those services which use legal authority and procedures on behalf of the client.

These services include conservatorship, guardianship, and committee of incompetancy. The three procedures, which must be initiated in State Supreme Court or County Court, can be differentiated as follows:

Conservatorship - Mental Hygiene Law, Article 77, sets forth the procedures for the designation of a conservator. The conservatorship does not carry with it the stigma of a declaration of incompetancy. Conservators manage a client's property and business affairs and provide necessary personal and social protective services. A proposed plan to insure the preservation, maintenance, and care of the proposed conservatee's income, assets, and personal well-being must be included in the conservatorship petition.

Guardianship - A guardian is invested with the legal authority and charged with the duty of not only managing a client's property, but also of taking care of the client. In New York, it is a method of providing protection for the mentally retarded adult.

Committee of Incompetancy - Mental Hygiene Law, Article 78, sets forth the procedures for the appointment of a committee for a person who is incompetant to manage himself or his affairs or is a patient in a mental institution. A committee of one or more persons may be appointed by the court to have custody of the person or property of the person who is incompetent.

3. Financial management.

In addition to social and legal services, financial management can be utilized. This intermediate step provides financial protection but, unlike conservatorship, does not require a court order.

Power of Attorney is a procedure which is essentially a written agreement between the client and another individual giving that person the authority to perform certain tasks on behalf of the client and conduct business on his behalf. Power of Attorney can be cancelled by the client at any time. This procedure probably will not be initiated or participated in by caseworkers and, as a protective measure, it probably has limited applicability.

For seriously impaired adults, unable to manage money and whose economic status is such that they require financial support, there are both state and federal regulations establishing procedures caseworkers can follow in providing such funds. State regulations call for three methods of payment:

1) restricted money payments, where money from Department of Social Services is required to be used in a specified way; 2) indirect or vendor payments, where an order is issued to a vendor to furnish some good or service; 3) protective payments, involving a check made payable to an individual other than the recipient to pay for goods or services.

Federal Social Security procedures provide for a Representative Payee. This procedure specifies that if a person is receiving OASDI or SSI benefits and cannot manage the benefits himself, a representative payee can be appointed to receive the benefits on his behalf. Although this procedure has been utilized mostly for those residing in nursing facilities, caseworkers can also utilize this procedure for individuals residing in the community. In the event that no other responsible individual can be found, the caseworker would then assume this function.

Note: See the section on Audiovisual aids for the videotape "Issues in Legal Protective Services for Adults."

G. Steps in the PSA Case Management Process

It is important for the caseworker to be aware of specific steps to follow while handling a protective services case. Although ordinary principles of social casework are followed, protective cases may include the added dimension of the possible need for legal intervention.

All cases start with the intake process. The client may initiate the contact or may be referred by family, friends, or another agency. It is the job of the intake worker to get as much information as possible from the client in order to determine the nature of the case and whether or not the client is in imminent danger. If the worker determines that the case is, or might be, a protective services case, it should be brought to the immediate attention of the PSA unit. In cases where there is immediate danger, it may be necessary to remove the client to a safe environment even before entry of the Protective Services unit - a step which is authorized by statute for either voluntary or involuntary clients. However, at this point, the agency attorney or the attorney who has been designated as consultant on PSA issues should be notified. If the client is assessed as capable or has responsible persons who can help, general rather than protective services may be required. Until such determination is made, however, it is appropriate to classify such cases as "Protective."

Once the PSA caseworker receives the case, the following stages and questions will help him to advance the case.

STAGE ONE: Client Assessment

1. What information is available on this case?
2. What involvement have agencies had with the client to this point in time?
3. What measures, if any, need to be taken in this case to further investigate and/or clarify the facts?
4. What are the important factors to consider?

5. Does sufficient information exist to go on to Stage Two? If not, answer #6; if so, go on.
6. Set a time frame for investigation and decide what mechanisms will be used.

STAGE TWO: Definition of the Problem

1. What are the client's Primary and Secondary needs?
2. What is a reasonable goal for the client? In what way will she be involved in the process?
3. What services are available for meeting the client's needs?
4. Are there any alternative courses of action?

STAGE THREE: Intervention

1. What courses of action appear to be most feasible?
2. Decide on a course of action:
   a. short-term?
   b. long-range?
3. What roles and responsibilities will facilitate delivery of services?
4. What mechanism should be employed for coordination and follow-up?
5. What are some of the barriers and/or facilitators to the client's progress or to the plan itself?

STAGE FOUR: Evaluation

1. What is the likelihood that your course of action will meet your goals for the client?
2. What are the client's needs for further monitoring?
3. What methods could be used to obtain feedback on a Protective Services for Adults case?

H. The PSA Professional Network

PSA should be viewed as an interorganizational system of care for individuals who usually have multidimensional problems. In order to provide comprehensive services to the client, it may be necessary to involve a number of service providers. A PSA network draws upon varying degrees of a community's resources, services, and programs with regard to each client's specific needs. A PSA network may consist of, in addition to a caseworker from the departments of social services, representatives of health, mental health, aging, and private agencies, as well as the community at large.

Case management responsibility is the core of protective services, and it is a responsibility the DSS caseworker usually assumes. Case management entails overall responsibility for the client's well-being; it involves seeing that services are appropriate and complete. In order to achieve this, the caseworker must be able to thoroughly assess a situation, develop a plan of action, identify alternatives if appropriate, and monitor and coordinate the provision of service. For this to be done effectively, the caseworker must have a good knowledge of community resources and how these resources can be utilized.

Although the caseworker assumes the case management function, this is not to say that he has sole responsibility for the provision of protective services. A shared responsibility should exist among the various service providers within the community. The caseworker can be seen as a facilitator of the coordination of services. To better coordinate services, the caseworker may call a case conference to discuss a specific case with other professionals in the community. In this way, each member of the group plays a supportive role to each other, and no one agency has sole responsibility for averting crises or providing service on a case-by-case basis.

As a case manager, the caseworker should be aware of his facilitating or blocking behaviors as he works with other representatives in the PSA network. (The chart in the case simulation, Problem Solving Guide, can help the caseworker to analyze his behaviors.) See Appendix 2.

I. Role of the Agency in Relation to the Caseworker

Since protective services presuppose intervention by an individual into the life of another, the agency must make clear to its caseworkers under which circumstances it is appropriate for them to intervene. Even when such action is taken appropriately, there is the possibility that legal action for damages may be brought against agency personnel charging deprivation of civil liberties. In most instances, agency personnel will have "qualified or limited immunity" from prosecution. In order to prosecute an agency official, the plaintiff must be able to prove that the employee of the agency knew or should have known of the potential for interference with the client's constitutional rights.

Clear guidelines must be written by the agency for caseworkers to follow and to which they can refer. The agency must also provide constructive supervision to its caseworkers as they carry out the various steps in the PSA process. Supervision must be in sufficient quantity, for in working in protective services there is an increased need for guidance and support. Above all else, the agency should assume responsibility for its agent, the caseworker.

J. References

Burr, J. J. *Protective services for older persons.* (P.A. report No. 54, Bureau of Family Services.) Washington, D.C.: U.S. Government Printing Office, 1964.

Hall, G., & Mathiasen, G. *Overcoming barriers to protective services for the aged.* New York: National Council on the Aging, 1968.

Hemmy, M. L., & Farrar, M. Protective services for older people. *Social Casework*, 1961, *42*(1), 16-20.

Hobbs, L. Adult protective services: A new program approach. *Public Welfare*, 1976, *34*(3), 28-37.

New York State Department of Social Services, *Protective Services for Adults* (Bulletin 194). October 29, 1976.

Regan, J. J., & Springer, G. *Protective services for the elderly, a working paper.* (Prepared for the Special Committee on Aging, U.S. Senate.) Washington, D. C.: U.S. Government Printing Office, July, 1977.

Wasser, E. *Casework as the core of protective services.* Paper presented at a workshop on Protective Services for Older Adults. Portland, Oregon, November, 1967.

Welfare Research, Inc. *Protective Services for Adults (PSA).* (Final report on objectives 4 and 5 of WRI contract C-93026; prepared for NYSDSS.)

VI. ANNOTATED BIBLIOGRAPHY

A. Books

Hall, G., & Mathiasen, G. *Overcoming barriers to protective services for the aged*. New York: National Council on the Aging, 1968.

This report examines the distinguishing components of the protective service system - the preventive, supportive, and surrogate functions. It also identifies barriers to providing protective services and suggests ways to overcome these barriers through the use of case summaries.

Hall, G., & Mathiasen, G. (Eds.). *Guide to development of protective services for older people*. Springfield, Illinois: Charles C. Thomas, 1973.

Prepared for the National Council on the Aging, this report presents an overview of development in the field of protective services. It also has an excellent review of the literature.

Mathiasen, G. (Ed.). *Guardianships and protective services for older people*. Albany, New York: Fort Orange Press, 1963.

This book, prepared for the National Council on the Aging, provides an excellent review and analysis of legal proceedings that may be used on behalf of the elderly. It is probably the most complete presentation of the legalistic interpretation of adult protective services.

B. Periodicals

Fisher, L. D., & Solomon, J. R. Guardianship: A protective service program for the aged. *Social Casework*, 1974, *55*(10), 618-621.

This article describes one agency's approach to guardianship and protective services.

Hemmy, M. L., & Farrar, M. Protective services for older people. *Social Casework*, 1961, *42*(1), 16-20.

The authors summarize the findings of a survey of a sample of cases in which protective services were given, outline some of the resources and requirements necessary for giving protective services, and indicate responsibilities of the agency and social worker.

Hobbs, L. Adult protective services: A new program approach. Public Welfare, 1976, 34(3), 28-37.

This article, which provides an excellent overview of PSA, is divided into two parts. The first part "redefines" adult protective services, while the second part outlines program design and implementation.

Lehmann, V. Guardianship and protective services for older people. Social Casework, 1961, 42(5-6), 252-257.

This article deals with the use of legal authority in protective casework services for aged people and reviews the procedures involved in placing a person in a mental hospital.

Wasser, E. Responsibility, self-determination, and authority in casework protection of older persons. Social Casework, 1961, 42(5-6), 258-266.

The question and use of professional responsibility in protected casework services with aged clients are examined with careful reference to the definitions and concepts involved.

VII. SUPPLEMENTARY READING MATERIAL

Bloom, M., & Nielsen, M. The older person in need of protective services. Social Casework, 1973, 52(8), 500-509.

Dublin, J. L. Public welfare's role in providing protective services for the aging. Public Welfare News, 1965, 29, 3-8.

Horowitz, G., & Estes, C. Protective services for the aged. Washington, D. C.: U.S. Department of Health, Education and Welfare, Office of Human Development, Administration on Aging, 1971.

Report of the national protective services project for older adults. Washington, D. C.: U.S. Department of Health, Education and Welfare, Social and Rehabilitation Service, Community Services Administration, 1971.

VIII. BROCHURES AND PAMPHLETS

Regan, J. J., & Springer, G. Protective Services for the Elderly: A Working Paper. (Prepared for the Special Committee on Aging, U.S. Senate.) Washington, D. C.: U.S. Government Printing Office, July, 1977.

This pamphlet provides an excellent overview of protective services for older adults. Chapter One discusses the need and nature of protective services, Chapter Two deals with social work aspects of PSA, and Chapter Three explores the legal aspects of PSA. The paper is concluded with model statutes on various aspects of PSA, such as power of attorney, conservatorship, etc.

Your Duties as Representative Payee (DHEW Publication # (SSA) 75-10076).

This brochure discusses the responsibility of someone handling another's social security or health insurance benefits. Specifically discussed are the duties involved, what should and can be done with the benefits, how benefits should be used for an institutionalized person, when benefits may be given to the beneficiary's relative, and what the accountability is while being a trustee or when terminating that role.

Available from: Department of H.E.W.
Social Security Administration
Washington, D.C. 20036

OR

Local SSA

IX. AUDIOVISUAL AIDS

RIGHTS OF AGE

16mm film/Black & White
28 minutes, 1967
Available from: New York State Department of Social Services or New York University
Rental price only at NYU: on request

An elderly, frail widow finds her independence threatened after a bad fall in her home, thereby involving her with community health and welfare agencies. Following her recovery, a social worker counsels her and she moves to public housing for the elderly. This film not only shows the need for more and improved services for the elderly, but it also raises questions regarding how well-suited these services are to the individual as a total human being.

THE YELLOW LEAF

16mm film/Black & White
28 minutes, 1971
Available from: New York State Department of Social Services
No rental fee in New York State

This film shows an elderly widow who is forced to leave her daughter's household to live in a home for the aged. Shocked and disappointed initially, she overcomes her dejection when she finds that the home offers friends, new interests, and a measure of independence. Although somewhat dated, the film can provoke discussion of the need for protective services.

LEGAL ISSUES IN PROTECTIVE SERVICES FOR ADULTS

1" videotape/Color
107 minutes, 1977
Available from: New York State Department of Social Services or Continuing Education Project
No rental fee in New York State

Three attorneys present material on mechanisms for legal intervention to an audience of local DSS and OFA workers. Included is an overview of appropriate sections of Mental Hygiene Law, Public Health Law, Criminal Procedure Law, and the Family Court Act. Power of Attorney, Representative Payee, Incompentency Proceedings, and

Conservatorship are also examined, as well as a discussion of the clients' perspective and rights. It concludes with a question and answer session between the attorneys and the audience.

(See the Discussion Question section for outlines of the presentations and issues for discussion.)

X. DISCUSSION QUESTIONS

1. The following discussion questions could be used with the film, "Rights of Age."

    A. Did Mrs. V. make the decision or did others make them for her? Who defined the problem?

    B. What were the reasons in favor of her staying in her house? What needs, if any, were being fulfilled?

    C. What were the reasons in favor of her leaving her house? What other needs, if any, were being neglected in Mrs. V.'s old home? What needs, if any, were fulfilled in her new home?

    D. Is there a dilemma portrayed by this case? If so, what?

    E. Were all relevant parties consulted? If not, who else might have been involved?

    F. What Protective Service issues were raised in the other cases (e.g., the woman who was hospitalized)? What about the issues of Free Speech/Public Abandonment?

2. Many PSA clients either don't believe they need help or refuse to accept such help as a matter of pride.

    A. What are some of the reasons why a client would resist help?

    B. What strategies can the caseworker use to gain the cooperation of the involuntary client?

    C. How far should the caseworker go in attempting to provide service to an involuntary client?

3. The Fourteenth Amendment provides that "(no) State (shall) deprive any person of life, liberty, or property without due process of law." Frequently the PSA caseworker must judge whether action should be taken which takes from the client some or all of these rights.

    A. Under what circumstances do you think a client's rights would be violated?

    B. Where do you draw the line between protecting the client's social and physical well-being, and violating his constitutional rights?

4. It has been said that many PSA clients are inappropriately placed in institutions because it is easier to commit them than to find the means to maintain them in the community.

   A. How do you react to this statement? Why?

   B. Realistically, how much time and effort can be afforded to each client?

5. The following outlines and discussion questions can be used in conjunction with the videotape, Legal Issues in Protective Services for Adults.

   I. Means of Legal Intervention - Richard Ippolito

      A. When to Intervene - Parens Patriae
      B. Family Court Act
      C. Criminal Procedure Law
      D. Mental Hygiene Law
      E. Public Health Law
      F. Points to Remember

         1. Try persuasion first; remember client's rights; you must provide facts.
         2. Either Family or Criminal Court can have jurisdiction; Family Court has broad powers; you may be present in court.
         3. Need evidence of mental illness plus likelihood of serious harm; you can secure needed evaluations.
         4. Health officer can enter any premises if health hazards or nuisances are alleged.

   II. Four Legal Protective Services - Allen Federman

      A. Power of Attorney

         1. Voluntary, easiest, flexible, not affected by changes in health.

      B. Representative Payee

         1. Appointed by Social Security for SSA and SSI recipients.

      C. Incompetency Proceedings

         1. Power over property and person; only when Conservatorship is inadequate.

D. Conservatorship

1. Device to use resources appropriately; need medical report; almost anyone can be conservator.

III. PSA: Purpose and Problems - Larry Faulkner

A. Client's Viewpoint
B. Community Care: Some Problems
C. Conservatorship and Client's Rights
D. Legal Money Management: Some Weaknesses
E. Concluding Remarks
F. Points to Remember

1. Try to prevent placement.
2. Remember client's wishes.
3. Community care can be difficult, but not impossible.
4. Power of Attorney, etc. useful but not magical.
5. You must believe in and work for client.

IV. PSA: Some Issues Without Answers

These philosophical, legal, and professional issues are intended to provide the basis for thought and discussion. They represent controversies that have historically both plagued and been skirted by professionals and the courts. While there are no answers, it is hoped that in pondering them, a better understanding of case situations and the often difficult and perplexing decisions they demand may be developed.

1. Does a social preference for the patient's right to be free amount to an unfortunate endorsement of his or her right to remain sick and/or die as well?

2. Benjamin Wolman has said in *The Therapist's Handbook*, "Suffering people have the right to seek or refuse help. Ultimately it is the patient who determines *whether* he will seek help and *whom* he will seek it from."

   Is this basic human freedom always preserved in the field of PSA in that a person's liberties are involuntarily curtailed under certain conditions? Does this involuntary treatment raise moral and/or legal issues?

3. Does mental illness categorically prevent an individual from accurately perceiving reality and making reasoned judgments?

4. The O'Conner decision (1974) seems to be moving the courts in the direction of requiring a determination of dangerousness as the sole grounds for involuntary commitment, but left unanswered two larger questions.

   A. May a state impose confinement on a non-dangerous mental patient for the purpose of treatment?

   B. May the state, for purely custodial or caretaking purposes, confine an individual not dangerous to others but not capable of living safely if unattended?

5. If a psychiatrist's prediction of dangerousness is little more reliable than a layman's judgment whether someone will commit a criminal act, the use of prediction of dangerousness may be an inappropriate index. Therefore, what, if any, grounds are sufficient and what minimum degree of reliability should be required?

6. Does a person have a right not to be discharged against his will? Does a person have a right to remain in a facility? Does a person have a right to asylum?

7. Which fundamental right is paramount?

   - individual self-determination
   - right of the state to act in the best interests of its citizens

8. A related issue is who determines "best interests" and how are they determined?

9. In a hierarchy of values, which is paramount?

   - physical and emotional well-being
   - freedom

10. How do we balance our tradition of individuality and self-determination vs. our humanitarian instincts to help?

11. Who needs protection and under what circumstances and conditions may we provide it?

12. Given that most "protectives" do not desire assistance, in whose opinion are they considered a problem?

13. Given their resistance to assistance, is assistance given to relieve the client's burden or to relieve the psychological discomfort of the helping professional?

14. At what point do we balance the patient's rights with those of others so that the patient is allowed the chance to demonstrate whether he or she remains dangerous?

XI. INSTRUCTIONAL STRATEGIES

A case simulation is given as this module's instructional strategy. Because of its complexity, the method is outlined in detail.

1. Objective: To help the trainee integrate and apply the components of the PSA module; to test organizational and professional role perceptions; to study and refine casework skills; to stimulate an awareness of the important factors in working with other agencies.

Method: A. Mechanics

1. Group size - Eight role players are needed. There may be from 1-3 observers.
2. Time required - Approximately 1-3/4 hours.
3. Group leaders - One leader per group is optimal, although one leader could oversee two groups.
4. Physical setting - The room should be conducive to discussion. Groups should not be too near to each other. Chairs should be around a conference table.

B. Materials (see Appendix 2)

1. Case cover sheet - Contains general information about the case. One per participant.
2. Workshop charge - An outline of the case management process. One per participant.
3. Problem solving guide - Lists behaviors facilitating or blocking the case management process. One per participant.

4. Role sheets - Each role has a sheet with information unique to that role. The agencies and roles represented are DSS, OFA, DMH, DH, State Police, homemaker supervisor, physician, Mr. M.'s son, and observer. Each participant plays a role.

5. Name plate - Each participant role should have a name plate made on a folded 5"x7" card. This helps players identify each other during case simulation.

6. Pen and paper - Should be available for those requesting.

C. Process

1. Introduction (15 minutes)

   a. Trainer introduces the case simulation by explaining that each person will assume the role of an agency worker present at a PSA case conference called by a DSS worker or will assume the role of an observer. The trainees are to work on the case as they would work on an actual case.

   b. Trainer hands out case cover sheet and workshop charge and allows a few minutes for trainees to look over.

   c. Trainer explains purpose of each:
      i. Workshop charge - A guide to the case management process. Broken into four stages with an explanation for each. The group's objective is to complete all four stages.
      ii. Case cover sheet - Contains general information about the case.

   d. Trainer explains that once in small groups, participants will assume roles that will provide each of them with unique information about the case, their roles and available resources. Some roles include prior experience with the case. Thus, it is important for the group to collect and synthesize the available information. Trainer should explain that the list of resources provided is a guide to those resources typically available in a given county. If the trainees are aware of other resources in their own county, they may be used in the exercise.

2. In Group (90 minutes)

   a. Trainees break into groups of 9-11 by whatever means chosen by trainer (assign groups, trainees volunteer, trainees "count off").

   b. Once in place, leader places name plates on table. The observer should physically position himself outside of the group. If there are players in group from the agencies, they are assigned that role (e.g., DSS worker is assigned DSS caseworker role). If there is more than one worker from an agency, leader should allow them to choose the role between themselves. Other trainees then choose roles from the remaining name plates.

   c. Leader distributes role sheets, explaining again that each role has unique information.

   d. Leader allows about 5 minutes to read role sheets and explains that the group will have about one hour to move through the four stages of the workshop charge. Leader can structure this into 15-minute units if desired.

   e. After answering any questions, the DSS roleplayer is asked to start the case conference. The observer should not participate in the discussion.

f. Leader should give group a final 10-minute warning.

g. At one hour, leader calls time and asks players to come out of role. Leader distributes problem solving guide and explains the observer's purpose and how the observer(s) used the guide to monitor the group.

h. Leader asks observer(s) to make reports and then group discusses the exercise.

i. At the end of the discussion, group selects one or more persons to report to the larger group.

3. Notes to Leader

a. During the hour the group is role playing, the leader acts as an observer. He is to sit apart from the group and be unobtrusive. He is to intervene only if after a significant amount of time (e.g., 1/2 hour) there are problems affecting the group operation. For example, if a role-player gives incorrect information or is unaware of crucial information on his role sheet.

b. Leader should not be afraid to let group struggle, for this often provides the most rewarding learning experience.

D. Report Out

1. Small groups reconvene and the trainer asks each group to make a report. Discussion should follow.

XII. PRE- AND POST-KNOWLEDGE QUESTIONS

1. T or F — A client who has sufficient resources to pay for protective services may not receive any services unless he agrees to pay for them.

2. T or F — The Representative Payee procedure for the management of a client's financial resources requires court action.

3. T or F — Interagency cooperation is necessary in a protective services case to assure that no single worker or agency has to assume the sole responsibility for providing services or averting crisis.

4. T or F — A PSA case is identified more by the characteristics of the person needing help than by the services needed.

5. T or F — Case coordination will fail if participating organizations have different levels of involvement.

6. T or F — The New York State Conservatorship Law is designed to provide service to an impaired person who cannot manage his affairs, while avoiding the stigma of incompetency.

7. T or F — The conservator's role is to act as a financial manager; he has no responsibility for the personal well-being of the conservatee.

8. T or F — Power of Attorney is a legally binding agreement between two people,giving one party the power to execute legal and financial affairs for the other.

PRE- AND POST-KNOWLEDGE QUESTIONS/KEY

1. F
2. F
3. T
4. T
5. F
6. T
7. F
8. T

APPENDIX 1: DEFINITION OF PROTECTIVE SERVICES FOR ADULTS

DEFINITION: Services to individuals 18 years of age or older who are unable to protect their own interests, harmed or threatened with harm through action or inaction by another individual or through their own action due to lack of awareness, incompetence or poor health which results in physical or mental injury, neglect or maltreatment, failure to receive adequate food, shelter or clothing, deprivation of entitlements due them, or wasting of their resources.

Such services are limited to:

(a) Identifying such adults who need assistance or who have no one willing and able to assist them responsible;

(b) Providing prompt response and investigation upon request of adults at risk or other persons acting on their behalf;

(c) Diagnosing the individual's situation and service needs;

(d) Providing counseling to such adults, their families, other responsible persons or to fiduciaries, such as representative payees, on handling the affairs of such adults;

(e) Arranging for appropriate alternative living arrangements in the community or in an institution;

(f) Assisting in the location of social services, medical care and other resources in the community, including arrangement for day care in a protective setting;

(g) Arranging for guardianship, conservatorship, commitment or other protective placements as needed;

(h) Providing advocacy and assistance in arranging for legal services to assure receipt of rights and entitlements due to adults at risk;

(i) Functioning as a conservator, representative payee or protective payee, where it is determined such services are needed and there is no one else available or capable of acting in this capacity;

(j) Providing homemaker and housekeeper/chore services to meet the goal of protection for adults who demonstrate specific functional deficits. The provision of such services is to be limited to 6 months when provided without regard to financial criteria and only when efforts to secure funding from client or other resources have failed.

NATIONAL GOAL RELATIONSHIP: III

METHOD OF PROVISION: Direct provision, purchase private, purchase public

SERVICE OBJECTIVE: To provide Protective Services to 16,162 individuals at a cost of $5,558,968.

CATEGORIES OF INDIVIDUALS ELIGIBLE UNDER TITLE XX:

All individuals without regard to income, except as provided in item (j).

Reproduced from the Comprehensive Annual Social Service's Program Plan for New York State, October 1, 1977 to September 30, 1978.

APPENDIX 2: CASE SIMULATION

CASE COVER SHEET

Mr. M. is a 75-year-old man living alone in the woods in the foothills of a mountainous area of New York. He has been married twice; his first wife died and his second wife and he were divorced approximately twenty-five years ago soon after the birth of a son. It was soon after that he assumed a reclusive life style in the wooded area and obtained the necessities of life by walking a mile to the main road and hitching a ride into town. He is somewhat slow and forgetful in his manner, but is still quite strong.

Mr. M. came to the attention of the Department of Social Services caseworker on a referral from the State Police who received repeated calls from the man. At the time of the initial visit in mid-November, Mr. M. was caring for himself quite well, getting out about once a week for groceries, mail, etc.; however, with heavy snowfalls, several weeks went by without a trip to town.

Case Simulation

WORKSHOP CHARGE

Setting: Case Conference called by Dept. of Social Services Caseworker.

STAGE ONE: Client Assessment

Purpose:
1. What information is available on this case?
2. What involvement have agencies had with the client to this point in time? (Jan. 28)
3. What measures, if any, need to be taken in this case to further investigate and/or clarify the facts?
4. What are the important factors to consider?
5. Does sufficient information exist to go on to stage two? If not, answer #6; if so, go on.
6. Set a time frame for investigation and decide what mechanisms will be used. Also include some method for reporting back to the group the progress made.

STAGE TWO: Definition of the Problem

Purpose:
1. What are the client's Primary and Secondary needs?
2. What is a reasonable goal for the client? In what way will he be involved in the process?
3. What services are available for meeting the client's needs?
4. Brainstorm alternative courses of action.

STAGE THREE: Intervention

1. Narrow alternative courses of action.
2. Decide on a course of action
   - a. Short-term?
   - b. Long-range?
3. Define roles and responsibilities for delivery of services.
4. Decide on mechanism for coordination and follow-up.

5. Define any barriers and/or facilitators to the client's progress or to the plan itself.

STAGE FOUR: Evaluation

1. What is the likelihood that your course of action will meet your goals for the client?
2. What are the client's needs for further monitoring?
3. List the methods you could use to obtain feedback on a Protective Services for Adults Case?

DEBRIEFING IN LARGE GROUP

1. What were the results of the Group Interaction?
2. What did you learn?

Case Simulation

OFFICE FOR AGING

CASE INFORMATION

You were not originally involved in this case. Since you did not know of the situation, you were not providing any services or assistance. You were called to the case conference because it was felt that your organization could help assume a shared responsibility with regard to this case.

RESOURCES

You have a small, relatively young organization, but you also have a number of supportive services available to senior citizens 60 years of age and over which would help them remain within their own community. You work with many church groups, civic organizations, as well as private and public organizations, to meet the needs of the elderly. Your organization has set up the following services in conjunction with other parties:

Friendly Visiting Program
Rural Transportation Program
Meals-On-Wheels Program
Telephone Reassurance Program

ROLE INFORMATION

Since you are a young organization, you are still carving out your role in the community. You have limited funding for developing new programs. Therefore, you must rely heavily upon your working relationship with key community people and organizations. Your organization is eager to do what it can for the neglected elderly.

Case Simulation

PUBLIC HEALTH NURSE

CASE INFORMATION

The client was visited after a referral was made by DSS on January 10.

You found Mr. M. receptive to your visit, during which time you took a medical history and observed Mr. M.'s present condition. He seemed undernourished and somewhat confused about where he was, who you were, dates, times, etc.

He had not seen a doctor since November and was reluctant when the suggestion of a medical exam was suggested.

RESOURCES

Your Agency can provide home nursing,but only under the following conditions: 1) A doctor must order such treatment; 2) The patient must be income eligible for Medicaid; and/or 3) The patient must be able to pay for service (on a sliding scale).

Your Agency can provide nutritional counseling.

Your Agency can provide transportation to some preventative clinics; i.e., blood pressure screening, T.B. check, etc.

ROLE INFORMATION

Your assessment is that,aside from nutritional needs, Mr. M. is in pretty good physical shape. However, his mental state concerns you a great deal. You would like to see some help offered to Mr. M. to meet his needs but feel your agency has limited resources.

Case Simulation

STATE POLICE

CASE INFORMATION

- Gave rides to man when hitching into town; seemed confused and unaware of where he was at times.

- Received repeated calls from man complaining of woman screaming around his house; no woman has ever been found; usually the man is calm by the time you arrive.

- Referred case to DSS and also have given written referral to the local Mental Health clinic.

- During your last investigation on a call from the Town Physician on January 10th, you found Mr. M. sitting on a rock 1/2 mile from his house in an extremely confused state, brandishing a bayonet and claiming there was a dead man in his house. A search of the house showed no body, but you did find broken mirrors on the floor; also the house was without heat, light or water. You inform DSS.

RESOURCES

Your regular patrol route is nearby the residence of Mr. M. Therefore, you can readily investigate calls.

You have the authority to remove Mr. M. to a hospital if an emergency situation exists where he is likely to harm himself or others.

ROLE INFORMATION

You are somewhat reluctant to continue your contacts with Mr. M. You think he is senile and confused and should be removed to a living arrangement where someone can look after him.

Case Simulation

TOWN PHYSICIAN

CASE INFORMATION

You are the General Practitioner in town. In November your initial contact with the client came through the State Police. They have received repeated calls from Mr. M., a 75-year-old man, complaining of screaming women running around his house. Investigations turn up nothing. The police indicate that the man walks or hitchhikes 3 miles into town every week for supplies and mail. The patrol car often gives him a ride, and the trooper notes that he doesn't seem to know where he is. The police are concerned about his apparent hallucinations and disorientation, as well as his physical condition. They asked you to visit the man in order to make a medical assessment. The police also made referrals to DSS and DMH. You visit the man the next day and find him amiable. He tells you he is doing fine and feels great. He lives in the woods by choice and doesn't get lonely. You ask him if he has any problems living in the house. He says nothing except that a woman sneaks around his house from time to time making noise. A physical indicates that the man is in very good health. The house is neat, the refrigerator well stocked; there is adequate electricity, heat, and water. You notify the police that the man appears to be fine, and you feel there is no need for another visit.

In January, you receive a phone call from the Town Supervisor. Mr. M. called him, saying that he had found a dead man in his house. He would like you to go out and check on it.

You knock on the door and Mr. M. answers, brandishing a bayonet and yelling, "There's a dead man in here." Fearing for your own life, you go back to town and call the police.

You receive a call from the local DSS caseworker asking you to attend a case conference on this man. You are now at this case conference.

RESOURCES

You can authorize an emergency admission to a hospital if the client appears to have a mental illness which is likely to result in serious harm to himself or others.

ROLE INFORMATION

You're unnerved by the latest incident at Mr. M.'s house. You've learned that the police found no body. Putting together your experience with the information from the police, you're convinced that this man poses a threat to himself and to others, even though your prior assessment did not corraborate this. You are in favor of having him committed.

Case Simulation

DSS CASEWORKER

CASE INFORMATION

- Initial contact in November found Mr. M. receptive to a visit and managing quite well on his own.
- You learned that his son is living on Long Island, and on the father's behalf, contacted him to make a visit.
- You learned Mr. M. gets a Social Security check of over $300.00/month and a pension of $200.00/month, as well as holding two savings accounts in Boston banks totaling $2500.00.
- On January 10 you were called in by the State Police to find Mr. M. without food, heat, water, and in an extremely confused mental state. He was unable to tell you when he'd eaten last. His water pipes were frozen, and he was gathering snow and melting it to drink.
- You took him to town to buy food and pick up his mail. There was a final disconnect notice from the Electric Company (which provided heat) that you persuaded him to pay.
- You take steps to have Mr. M.'s road plowed and the pipes thawed.

RESOURCES

Your agency has a homemaker service that can be provided if reimbursement is available or if the client is income eligible.

Although you have a caseload of 45, you have some time on your schedule to work on this case. Other Title XX Services could be made available.

ROLE INFORMATION

You have taken the initiative to organize this case conference in order to share information concerning the case and decide on a course of action.

Although Mr. M. is somewhat stable at the moment, you feel there is a need for continued supervision and input from professionals other than yourself.

You have concluded Mr. M. has problems managing his money, as well as indications that he has psychiatric problems; e.g., hallucinations, confusion, etc.

You are anxious to help Mr. M., but feel you need help from others in order to meet his pressing needs.

Case Simulation

HOMEMAKER SUPERVISOR

CASE INFORMATION

You are in charge of placing and monitoring homemakers for your local Homemaker Services Corporation. You are under a purchase of service contract with the County DSS.

You received a call from a DSS Caseworker asking you to attend a case conference concerning an elderly man. The caseworker tells you that the client is 75-years old, lives in the woods 3 miles from town, appears frequently confused, and has had difficulty recently in purchasing food and managing his money.

RESOURCES

Your agency can provide shopping, cooking, cleaning,and limited transportation services.

ROLE INFORMATION

You are wary of getting involved because in the past your homemakers have been asked to assume financial responsibility for clients without legal authority. Second, you've heard rumors about a recent DSS case where the client threatened the town doctor with a knife. You suspect that this might be the man, and you're reluctant to place your homemakers in a dangerous situation.

Case Simulation

MR. M.'s SON

CASE INFORMATION

In early November, you received a call from DSS who contacted you on Long Island and informed you about your father's situation. Later in January, your father had called the State Police complaining of a dead man inside his house. Upon investigation, no body was found, but your father was without food, heat, water, and was in an extremely confused mental state.

In mid-January, you are planning to make a trip from Long Island to see your father and attend a case conference.

RESOURCES

You are currently in Law School. You are managing very well. You have the capability of assuming more responsibility for your father. However, you don't want to become involved in this situation.

ROLE INFORMATION

You are 25 years of age and living on Long Island with your mother. You have lived with your mother since your parents' divorce when you were an infant. Thereafter, you saw your father about once a year and never for more than a day or two at a time. It has been 9 years since you last saw him. You are concerned about him, yet bitter about his lack of involvement and concern in your life.

Case Simulation

MENTAL HEALTH WORKER

CASE INFORMATION

In November you received a written referral from the State Police regarding a 75-year-old man living alone in his house. The State Police reported that this man was often found hitchhiking to and from the grocery store that is located about three miles from his home. The State Police stated that at times he seemed not to know where he was. They had felt that he needed to be looked in on occasionally or needed to be transferred to a protective home environment where someone could look after him.

At the same time, the State Police had made a written referral to DSS. You chose not to make a home visit because you felt that the man's rights would be ignored if someone from the Mental Health Clinic made a visit.

RESOURCES

Out-patient psychiatric unit at local general hospital which is capable of doing in-house diagnosis and short-term treatment.

ROLE INFORMATION

Yours is a small unit capable of handling those individuals brought into your clinic. However, your role regarding outreach is limited due to staffing and resources.

Case Simulation

OBSERVER

The purpose of this simulation is to have the group move through the four stages (see Workshop Charge) of the helping process.

Each participant will be given individual case, resource, and role information. It will be the responsibility of the group to coordinate this data, deal with differing roles, and develop a mutual course of action.

INSTRUCTIONS: Using the Workshop Charge as a guide, you are to observe how the group moves through the case.

Trace the group's progression through the various stages of group problem solving (see Problem Solving Guide), keeping the following things in mind:

1. How does the group go about introducing and presenting the case?
2. How does the group stimulate the exchange of knowledge and experience?
3. Is the group keeping the discussion in line with its objectives?
4. How does the group deal with the different roles of its members?
5. What actions did the group take that facilitated or blocked effective problem solving.

Record your impressions on the paper provided. At the end of the exercise, you will be asked to share your observations with the group.

Case Simulation

PROBLEM SOLVING GUIDE

WORKSHOP STAGE	PROBLEM SOLVING STEPS	FACILITATING BEHAVIORS	BLOCKING BEHAVIORS
I	1) Collecting Information	a) Initiating activity. b) Clarifying information. c) Summarizing information. d) Testing group opinion and recording major elements of problem.	a) Generalizing instead of being specific. b) Being self-centered rather than case-centered.
II	2) Define Problems	a) Seeking information. b) Giving information. c) Gate Keeping - making sure everyone has input. d) Encouraging - being responsive, place value on contributions.	a) Premature decision making. b) Jumping to conclusions. c) Opinions presented as facts. d) Seeking personal recognition. e) Going off target. f) Criticizing.
	3) Identifying Alternative Solutions	a) Giving information. b) Coordinating data. c) Collaboration - working as a team. d) Diagnosing - analyzing main blocks to progress.	a) Over-analyzing data. b) Judging people rather than their ideas. c) Self-confession. d) Withdrawal from group. e) Competing.
III	4) Testing Alternatives	a) Reality testing - how well it works. b) Compromise-conciliating different points of view.	a) Judgments on basis of values and biases.
	5) Decision Making	a) Summarizing.	a) Polarization-coalitions, agreements, group divisions.
	6) Intervention	a) Recording - who, what, when, where, why.	
IV	7) Follow up	a) Evaluation of action.	

APPENDIX A: SAMPLE EVALUATION INSTRUMENT

PARTICIPANT EVALUATION

In order to insure that the training sessions are meeting your needs, you are asked to assist by completing this form. Please answer all questions. Your responses will not be made available or known to anyone but the training staff.

Training Program ______________________________

Date: ____________________

When answering the following questions, print the number which most accurately represents your answer in the space at the left.

1. ______ Overall, how would you rate this program?

1	2	3	4	5
excellent	good	fair	poor	very poor

2 -7. How do you rate the trainer(s) on the following factors?

1	2	3	4	5
excellent	good	fair	poor	very poor

2. ______ Organization
3. ______ Explanation of materials
4. ______ Facilitating discussion
5. ______ Maintaining interest
6. ______ Knowledge of subject
7. ______ Method of presentation

8 -15. How do you rate the methods and scheduling used on the following items:

1	2	3	4	5
excellent	good	fair	poor	very poor

8. ______ Speakers and Resource people
9. ______ Reading materials
10. ______ Films/Videotapes and other aids

11._____ Exercises/worksheets

12._____ Large Group sessions

13._____ Small Group sessions

14._____ Physical facilities

15._____ Informal "free time" to interact with other participants

16. What part of the program did you like most? Why?

17. What part of the program did you like least? Why?

18. Please give any suggestions you have for improving the program or any general comments.

Thank you for your assistance and cooperation.

APPENDIX B: JOURNALS RELEVANT TO AGING

Adult Education
Adult Education Association of the United States of America
810 Eighteenth Street, N.W.
Washington, D.C. 20006

Adult Education is a quarterly journal which contains current theory and research in the field of adult education. In addition to empirical, theoretical, and review articles, the journal contains an extensive book review section and summaries of current reports that are available in adult education.

Adult Leadership
Adult Education Association of the United States of America
810 Eighteenth Street, N.W.
Washington, D.C. 20006

Although publication of the journal ceased in June of 1977, this periodical contained a variety of descriptive articles and reviews dealing with the implementation of programs and techniques of adult education.

Aging
U.S. Department of Health, Education, and Welfare
Office of Human Development/Administration on Aging
U.S. Government Printing Office
Division of Public Documents
Washington, D.C. 20402

This bi-monthly news magazine contains articles about programs involving older persons. Regular reports examine legislation and programs pertaining to older adults on the federal, state, and local levels, as well as what is taking place in other countries.

AARP News Bulletin
American Association of Retired Persons
215 Long Beach Blvd.
Long Beach, California 90801

Published monthly, except in August, this newspaper contains stories about legislation and programs for older adults. Many articles focus on older individuals and specific activities or hobbies of such persons.

Black Aging
National Council on Black Aging

P. O. Box 8522
Durham, N.C. 27707

This periodical, established in 1975, deals with many of the salient issues of aging pertinent to blacks. Combining newsletter and journal formats, the publication contains information about current legislation, policies and programs, and empirical research studies pertaining to older blacks. Recent issues have reflected more of an emphasis on research.

Clinical Social Work Journal
Human Science Press
72 Fifth Avenue
New York, New York 10011

Sponsored by the National Federation of Societies for Clinical Social Work, this quarterly publication examines historical, theoretical, and practice-oriented issues of clinical social work with individuals, couples, groups, and families.

Counseling Psychologist
American Psychological Association
1200 Seventeenth Street, N.W.
Washington, D.C. 20036

Theory and research in psychotherapy are the primary focus of this quarterly publication. Each issue deals with a topic of special interest to helping professionals.

Educational Gerontology
Hemisphere Publishing Corporation
1025 Vermont Avenue, N.W.
Washington, D.C. 20005

Published quarterly, this journal deals with theory, research, and practice pertaining to educational opportunities for and about older adults. Some of the topics that are covered in the journal are adult learning, curriculum development, counseling, and staff and professional training and development.

The Gerontologist
Gerontological Society
1 Dupont Circle
Washington, D.C. 20036

A bi-monthly publication of the Gerontological Society, The Gerontologist contains a variety of articles on theory, research, social policy, and current issues pertaining to the field of aging. Articles are written from a variety of perspectives, including but not limited to, theoretical, empirical, descriptive, and review.

Industrial Gerontology
The National Council on the Aging
1828 L Street, N.W.
Washington, D.C. 20036

Industrial Gerontology contains articles which deal with issues pertaining to work and age. In addition to empirical studies of employment, retirement, and the older adult, the journal contains numerous articles which describe relevant programs and policies. The journal is published quarterly.

International Journal of Aging and Human Development (formerly Aging and Human Development)
Baywood Publishing Company, Inc.
43 Central Drive
Farmingdale, New York 11735

This journal examines many of the salient aspects of social and psychological development throughout the latter portion of the life span. Published semi-annually, the journal consists primarily of experimental studies, though some articles emphasize the theoretical aspects of adult development.

Journal of Gerontology
Gerontological Society
1 Dupont Circle
Washington, D.C. 20036

One of two periodicals published by the Gerontological Society, this journal contains recent empirical studies in aging. Each issue is divided into three sections: biological and medical sciences; behavioral and social sciences; and social gerontology. Articles tend to emphasize the biological aspects of aging, geriatric medicine, and experimental gerontological psychology. Each issue also contains a listing of current publications in the field of aging. The journal is published bi-monthly.

Lifelong Learning: The Adult Years
Adult Education Association of the United States of America
810 Eighteenth Street, N.W.
Washington, D.C. 20006

Published for the first time in September, 1977, this journal replaces Adult Leadership. Like its predecessor, the journal is geared toward the adult education practitioner, as opposed to the researcher.

Modern Maturity
American Association of Retired Persons
215 Long Beach Blvd.
Long Beach, California 90801

This bi-monthly magazine contains news stories and feature articles which deal, to a great extent, with topics of special interest to retired persons and those who work with older adults. Articles cover topics such as legislation, health, travel, hobbies, and biographical sketches of older persons.

Omega - The Journal of Death and Dying
Baywood Publishing Co., Inc.
120 Marine Street
Farmingdale, New York 11735

Established in 1970, this international journal consists of articles pertaining to "the study of dying, death, bereavement, suicide, and other lethal behaviors." Articles are written from a variety of points of view, including psychology and psychiatry, medicine, law, sociology and social work, literature, philosophy, and theology.

Personnel and Guidance Journal
American Personnel and Guidance Association
1607 New Hampshire Avenue, N.W.
Washington, D.C. 20009
Attn: Subscriptions Manager

This journal, published ten times per year, contains articles, poems, and reviews which examine current issues in counseling and guidance. Articles are generally written from the theoretical or experiential, as opposed to empirical, point of view. The journal sometimes contains articles which are relevant to counseling middle-aged and older adults.

Social Casework
Family Service Association of America
44 East 23rd Street
New York, New York 10010

This journal, published ten times a year, contains articles on the theory and practice of social work. Articles discuss current programs and research in social work.

Social Service Review
The University of Chicago Press
5801 Ellis Avenue
Chicago, Illinois 60637

Established in 1927, this journal contains articles on policy, practice, and research in social work. Each issue contains an extensive book review section. Social Service Review is published quarterly.

Social Work
National Association of Social Workers

Business and Publications Office:
49 Sheridan Avenue
Albany, New York 12210

Editorial Office:
2 Park Avenue
New York, New York 10016

This bi-monthly publication examines pertinent issues in the field of social work. The emphasis of the journal is on current practices and research, new techniques, and problems of the profession.

Thanatology Journal (formerly Journal of Thanatology)
Highly Specialized Promotions
20 Schemerhorn Street
Brooklyn, New York 11201

Established in 1970 and published quarterly, the Thanatology Journal contains articles dealing with the psychological aspects of dying; reactions to death; loss and grief; and recovery from bereavement. These topics are covered from both a scientific and humanistic point of view.

APPENDIX C: ORGANIZATIONS RELEVANT TO AGING

Action
Washington, D.C. 20525

Sponsors RSVP, Score, Foster Grandparents.

Administration on Aging
Department of Health, Education and Welfare
330 Independence Ave., S.W.
Washington, D.C. 20201

Administers grant programs to stimulate development of public and private services for older people at state and local levels.

Association for the Advancement
of Aging Research (AAAR)
309 Hancock Bldg.
University of Southern California
Los Angeles, CA 90007

Professionals in the field of gerontology who organize and support expanded research efforts. Programs include organization of an "information bank" on aging research.

American Association of Homes
for the Aging (AAHA)
1050 17th Street, N.W.
Washington, D.C. 20036

Voluntary, nonprofit, and government homes for the aging. Conducts institutes and workshops.

American Association of
Retired Persons (AARP)
1909 K. Street, N.W.
Washington, D.C. 20049

Comprised of persons 55 or older. Encompasses community service programs; group travel; insurance; pre-retirement planning program; pharmacy services; Tax Aide; Institute of Lifetime Learning. Goal is "To improve every aspect of living for older people."

American Geriatrics Society
Ten Columbus Circle
New York, NY 10019

Professional society comprised of occupational therapists, physicians, social workers and so on who encourage and promote the study of geriatrics (stress on medical research).

American Institutes for Research
P.O. Box 1113
Palto Alto, CA 94302

In collaboration with NIMH, publishes Innovation, an experimental magazine serving as a channel to communicate information to mental health on innovative programs and techniques.

Center on Social Welfare Policy and Law
95 Madison Ave.
New York, NY 10016

Brings landmark cases in welfare law; develops materials for welfare rights groups; publishes Advocates Handbook.

Central Bureau for the Jewish Aged
225 Park Ave. South
New York, NY 10003

Serves as coordinating group through which the New York Metropolitan Jewish community can study problems of providing effective care for the aged (homes, hospitals, agencies, community centers).

Citizens for Better Care in
Nursing Homes, Homes for the Aged
and other After-Care Facilities (CBC)
960 E. Jefferson Ave.
Detroit, MI 48207

Information and referral service. Handles complaints; investigates and publicizes issues; initials legal and political action; trains volunteers; conducts research on alternatives to living in nursing homes.

Federal Council on the Aging
330 Independence Ave. S.W.
Room 4260
Washington, D.C. 20201

Periodically publishes a status report, as well as an annual report. An independent organization created by Congress to advise the President, Secretary of HEW, Commissioner on Aging, and Congress on matters relating to the special needs of older Americans. The council acts as advisor, appraiser, and reviewer of needs, policies, and programs for the aging. Acts as spokesman for older Americans, informs the public, and provides forums for discussion.

Gerontological Society
1 Dupont Circle
Washington, D.C. 20036

Professional organization of those interested in improving older people's welfare. Publishes The Gerontologist and the Journal of Gerontology.

Golden Ring Council of
Senior Citizens Clubs
32 West 38th Street
New York, NY 10018

A council which aims to "promote better living conditions for elderly people, social activities in clubs, and foster social action to improve legislation".

Gray Panthers
3700 Chestnut Street
Philadelphia, PA 19104

Activist group of people, young and old, who resent stereotyping.

Help Age International
P.O. Box 126
Watford WDI ZHG
Herts, England 32483

Publishes Help Age, a paper which brings together readable news of important changes that are taking place in the care of old people around the world.

HRS Geriatric Publishing Corp.
342 Pipe Stove Hollow Road
Mt. Sinai, NY 11766

Publishes "Geriatric and Residential Care," a monthly newsletter of interest to persons working with the elderly.

International Federation On Aging (IFA)
1909 K. Street N.W.
Washington, D.C. 20049

Federation of voluntary organizations from 13 countries that represent the elderly as their advocate and/or provide services to them.

Jewish Association for Services
for the Aged
222 Park Ave. S.
New York, NY 10003

A federation of local senior citizens' associations aiming to keep older adults in the community where possible and provide necessary services also involved in training social work students.

Legal Service for the Elderly Poor
2095 Broadway
New York, NY 10023

Funded through OEO. Comprised of lawyers who advise on legal problems and areas indigenous to the elderly. Also do research, education programs, publish articles, reports, maintain library.

Mental Health Services to the Aged
NIMH
5600 Fishers Lane Room 11C17
Rockville, MD 20857

Provides funding for research and development proposals that evaluate innovative approaches to income maintenance, physical and psychological adjustments, housing, and retirement.

National Alliance of Senior Citizens (NASC)
Box 40031
Washington, D.C. 20016

Purpose is to inform its membership and American public at large of senior citizens' needs and programs/policies being carried out by government and other groups. Represents senior citizen views before Congress and state legislatures. Compiles statistics.

National Association of Social Workers
1425 H Street N.W.
Washington, D.C. 20005

A professional society geared toward the advancement of the field of social work. In addition to involvement in lobbying activities, the organization publishes a journal, Social Work.

The National Caucus of the Black Aged
1730 M Street N.W. Suite 811
Washington, D.C. 20036

This organization advocates an improvement in the quality of life of older blacks.

National Council of Senior Citizens
1511 K Street N.W.
Washington, D.C. 20005

Organization of 3500 autonomous senior citizen clubs, associations, councils, and other groups with a combined membership of over 3,000,000 persons. Education and action group. (Supports various issues, including Medicare.) Sponsors rallies, workshops, provides speakers, helps organize and develop programs for local and state groups, works in behalf of political issues, encourages participation in social and political action activities.

National Council on the Aging
1828 L Street N.W. Suite 504
Washington, D.C. 20036

Research and services regarding the elderly. Numerous publications.

National Geriatrics Society
312 W. Wisconsin Ave. 3rd Floor
Milwaukee, WI 53203

Comprised of public, voluntary, and proprietary institutions providing long-term care and treatment of the chronically ill aged. Provides maintenance of standards, geriatric education; conducts clinical studies and reports.

National Institute on Aging
Attn: Ms. Jane E. Shure, Information Officer
Bldg. 31, Room 4B-32
900 Rockville Pike
Bethesda, MD 20014

Newest of the eleven National Institutes of Health. Dedicated to improving the quality of life of the elderly in America through biomedical, social, and behavioral research.

New York State Office for the Aging
Agency Building #2 Empire State Plaza
Albany, NY 12223

Central state government agency concerned with planning, coordinating, and administering programs and services for the aging.

Select Committee on Aging, Claude Pepper, Chmn.
U.S. House of Representatives
Room 712, House Office Bldg. Annex 1
300 New Jersey Ave. S.E.
Washington, D.C. 20515

Series of newsletters to House of Representatives relating information on Congressional legislation and administrative programs affecting the elderly.

APPENDIX D: ADDRESSES OF AUDIOVISUAL AIDS

Adult Services Project
Continuing Education Project
School of Social Welfare
State University of New York
at Albany
135 Western Avenue
Albany, NY 12222
(No rental fee is charged
for use of films.)

Carousel Films Inc.
1501 Broadway
New York, NY 10036

Concept Media
1500 Adams Avenue
Costa Mesa, CA 92626

Connecticut State Department
on Aging
Film Librarian
90 Washington Street
Hartford, CT 06115

Didactic System Inc.
56 North Avenue
Gorwood, NJ 07027

Films Incorporated
440 Pearl Avenue South
New York, NY 10016

Filmakers Library, Inc.
290 West End Avenue
New York, NY 10023

Human Resources Center
University of Texas
Austin, TX 78712

Learning Corporation of
America
1350 Avenue of the Americas
New York, NY 10019

Mass Media Ministries
2116 North Charles Street
Baltimore, MD 21218

McGraw-Hill Films
ACRM Educational Film
1221 Avenue of the Americas
New York, NY 10020

The Media Guild
P. O. Box 881
Solona Beach, CA 92075

New York State Department
of Social Services
Attn: Mr. John Lennon
Forms and Publications
800 North Pearl Street
Albany, NY 12204

New York State Office for
the Aging
Empire State Plaza
State Agency Bldg. #2
Albany, NY 12247

New York University Film
Library
26 Washington Place
New York, NY 10003

North Texas State University
Gerontological Film
Collection
Main Library
Denton, TX 76203

The Pennsylvania State
University
Audio-Visual Services
University Park, PA 16802

Phoenix Films, Inc.
470 Park Avenue South
New York, NY 10016

Psychological Films Inc.
Distribution Center
1215 E. Chapman Avenue
Orange, CA 92669

Roundtable Films Inc.
113 North San Vincente
Beverly Hills, CA 90211

South Beach Psychiatric Center
777 Seaview Avenue
Staten Island, NY 10305

Syracuse University
Film Library
Collendale Campus
1455 E. Colvin Street
Syracuse, NY 13210

Transit Media
P. O. Box 315
Franklin Lakes, NJ 07417

University Associates
7596 Eads Avenue
La Jolla, CA 92037

University of Illinois
Visual Aids Service
1325 S. Oak
Champaign, IL 61820

The University of Michigan
Audio Visual Center
416 Fourth Street
Ann Arbor, MI 48109

U.S. Social Security Administration
6401 Security Blvd.
Baltimore, MD 21335